Public Document Pack

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 31 January 2017
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

AGENDA

1 Declarations of Pecuniary and Non-Pecuniary Interests

2 Minutes of the Board Meeting held on 6th December, 2016 (HWB.31.01.2017/2) *(Pages 3 - 8)*

3 Minutes from the Children and Young People's Trust Executive Group held on 24th November, 2016 (HWB.31.01.2017/3) *(Pages 9 - 16)*

4 Minutes from the Barnsley Community Safety Partnership held on 23rd November, 2016 (HWB.31.01.2017/4) *(Pages 17 - 22)*

5 Minutes from the Provider Forum held on 7th December, 2016 (HWB.31.01.2017/5) *(Pages 23 - 26)*

6 Minutes from the Stronger Communities Partnership held on 22nd November, 2016 (HWB.31.01.2017/6) *(Pages 27 - 30)*

For Decision/Discussion

7 Health and Wellbeing Board Risk Register (HWB.31.01.2017/7) *(To Follow)*

8 Suicide Prevention Action Plan (HWB.31.01.2017/8) *(Pages 31 - 34)*

9 Future in Mind Transformation Plan - Presentation (HWB.31.01.2017/9) *(Pages 35 - 220)*

10 End of Life Care (HWB.31.01.2017/10) *(Pages 221 - 232)*

For Information

11 CCG Commissioning Intentions 2017/18 - 2018/19 (HWB.31.01.2017/11) *(Pages 233 - 248)*

To: Chair and Members of Health and Wellbeing Board:-

Councillor Sir Steve Houghton CBE, Leader of the Council (Chair)
Dr Nick Balac, Chair, NHS Barnsley Clinical Commissioning Group (Vice Chair)
Councillor Jim Andrews BEM, Deputy Leader
Councillor Margaret Bruff, Cabinet Spokesperson – People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson – Communities
Rachel Dickinson, Executive Director People
Wendy Lowder, Executive Director Communities
Julia Burrows, Director of Public Health
Lesley Smith, Chief Officer, NHS Barnsley Clinical Commissioning Group

Scott Green, Chief Superintendent, South Yorkshire Police
Emma Wilson, NHS England Area Team
Adrian England, HealthWatch Barnsley
Dr Richard Jenkins, Medical Director, Barnsley Hospital NHS Foundation Trust
Rob Webster, Chief Executive, SWYPFT
Helen Jaggar, Chief Executive Berneslai Homes

Please contact Peter Mirfin on 01226 773147 or email governance@barnsley.gov.uk

Monday, 23 January 2017

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 6 December 2016
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

MINUTES

Present

Councillor Jim Andrews BEM, Deputy Leader
Councillor Margaret Bruff, Cabinet Spokesperson - People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson - Communities
Wendy Lowder, Executive Director Communities
Julia Burrows, Director Public Health
Lesley Smith, NHS Barnsley Clinical Commissioning Group
Emma Wilson, NHS England Area Team
Adrian England, HealthWatch Barnsley
Helen Jaggar, Chief Executive, Berneslai Homes Chair of the Provider Forum
Diane Wake, Barnsley Hospital NHS Foundation Trust
Andrea Wilson, South West Yorkshire Partnership NHS Foundation Trust

33 Election of a Chair

In the absence of the Chair and Vice-Chair, the Board considered nominations for Chair of the meeting.

RESOLVED that Councillor Andrews be elected Chair for this meeting

(Councillor Andrews in the Chair)

34 Declarations of Pecuniary and Non-Pecuniary Interests

There were no declarations of pecuniary or non-pecuniary interests.

35 Minutes of the Board Meeting held on 4th October, 2016 (HWB.06.12.2016/2)

The meeting considered the minutes of the previous meeting held on 4th October, 2016.

RESOLVED that the minutes be approved as a true and correct record.

36 Minutes from the Children and Young People's Trust Executive Group held on 6th October, 2016 (HWB.06.12.2016/3)

The meeting considered the minutes of the Children and Young People's Trust Executive Group meeting held on 6th October, 2016.

RESOLVED that the minutes be received.

37 Place Based Local Plan (HWB.06.12.2016/5)

The meeting received a report giving an update of the progress made in developing the Barnsley Place Based Plan, and seeking consideration and approval of the current draft Plan for consultation. The Plan sought to align local health & social care to address demands holistically across in the system, and address the three challenges in relation to the health and wellbeing gap, the care and quality gap and the finance and efficiency gap.

The Plan sought to address inefficiencies and improve outcomes by doing things differently, to engage and collaborate with the public and agencies in this work and achieve better targeting of resources and prioritise the actions that would make the most progress. The intention was to develop a single integrated action plan, building on the Health and Wellbeing Strategy.

The meeting noted concerns about the continuity of services for local people, both during and after the transition, and the difficult of releasing resources required to deliver current services to allow the development of new, replacement, services. However, the meeting noted the value of service re-engineering, particularly to develop preventative services, noting the impact on the need for other interventions further down the line. There was evidence that the public wanted to see changes in how services were delivered, and to see new, community-driven, solutions to what where, in many cases, old problems.

RESOLVED:-

(i) That the Place Based Plan be approved as the basis for wider circulation and endorsement by all Partner Boards and public consultation and engagement;

(ii) That action plans be developed to take forward the Plan and be submitted to future meetings of the Board for endorsement in due course.

38 Sustainability and Transformation Plan (HWB.06.12.2016/4)

The meeting received a report summarising the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP), published on 11th November 2016, which was developed from the NHS 5 Year Forward view and was the basis for the Placed Based Plan, referred to at minute 37 above. The STP sought to set out a vision / ambition for the development of health services, but would be implemented by the Place Based Plan.

The vision was outlined in paragraph 4 of the report, and could be summarised as taking the necessary actions to help people live well in their area. This would need a conversation with the public about these actions and any changes, but with any specific proposals subject to detailed business cases and public consultation. Any proposals would be referred to the Board for consideration. The meeting noted the resource gap identified in the STP process, but this reflected the position if no changes were made. The importance of avoiding any actions that further increased health inequalities was emphasised.

RESOLVED that the vision, ambition and priorities of the plan be supported and all agencies work with STP partners at a South Yorkshire and Bassetlaw level to develop the priorities and to support the direction of travel set out in the STP.

39 Joint Strategic Needs Assessment (HWB.06.12.2016/6)

The meeting received a report on the Joint Strategic Needs Assessment (JSNA), summarising the main health and wellbeing issues in Barnsley. In addition to a formal report, an infographic illustrating the main issues had been developed, and the evidence base would also be made accessible via the Barnsley Council website in the form of briefings, profiles, infographics and more detailed reports. Work continued to review and develop the JSNA evidence base, in response to new information and feedback, so decisions can be made on the most accurate and timely data. In particular, there was a need for further work on how to access fuller data for harder-to-reach groups and with the Equality Forums.

The meeting discussed the importance of using the JSNA as the basis for developing plans and strategies for service provision. In particular, there was a need to focus on the main interventions that would result in the greatest impact on outcomes for service users, focusing on good health rather than health care. The relevance of the data to developing area commissioning, and in making that data available to Area Councils for this purpose, was noted. Given the reference in the JSNA to the need to tackle specific health issues, there was also an opportunity to provide web links to relevant support services from the JSNA website.

RESOLVED:-

(i) that the JSNA for Barnsley, as set out in the report now submitted, be approved, and it be used to develop plans and strategies to support good health in Barnsley;

(ii) that the possibility of providing links from the JSNA website to relevant support services be investigated.

40 Healthwatch Annual Report (HWB.06.12.2016/7)

The meeting received a presentation on the Healthwatch Annual Report for 2015/16, highlighting in particular the signposting and engagement work undertaken with people who use health and social care services and the impact that Healthwatch had been able to achieve on their behalf. The presentation made reference to the impact of Healthwatch in the specific area of services for people with hearing impairment or deafness, and highlighted the work in collecting and sharing the views of service users.

The presentation went on to set out the next steps for Healthwatch Barnsley, in particular to promote its activities and raise its profile, to expand the programme of outreach and promotion with health and social care front line staff, to continue the development of Healthwatch Champions, and provide opportunities to engage with members of the public. It was also intended to embed the feedback centre monitoring reports in its communication activities and to seek opportunities with its remit to bid for local/regional contracts. Specific priorities for 2016/17, based on the outcome the reflective audit and the comments collected over the last 12 months, would be the completion of work on access to general practice and CAMHS, and to continue to work with the Deaf Forum regarding access to Assessment and Care Management Services and to work with the Mental Health Crisis Care Concordat.

The meeting discussed the content of the annual report, and Members expressed their appreciation of the work done by Healthwatch volunteers. The Board reflected

on the importance of the insights provided by Healthwatch in relation to specific services, and the need for agencies to respond promptly to any observations made.

RESOLVED:-

(i) that the Healthwatch Barnsley Annual Report for 2015/16 be received and arrangements be made to share this with respective organisations;

(ii) that the proposed activities and priorities for 2016/17 be noted and the Senior Strategic Development Group support these activities by responding promptly to any queries or recommendations made by Healthwatch;

(iii) that the Board place on record its appreciation to Healthwatch members, volunteers and staff for their work over the past year.

41 Safer Barnsley Partnership Plan (HWB.06.12.2016/8)

The meeting received the Partnership achievements since the previous Plan and identifying a series of collective priorities which would make the most difference to achieve the best outcomes for individuals, families and communities in tackling crime and disorder, combating substance misuse and reducing reoffending. For the first time, the Plan had been subject to public consultation, and, although the number of responses were relatively small, the Partnership hoped that this was the first step in achieving better engagement on these issues. Members commented on the positive progress made in community safety issues as a result of the collaboration between the responsible agencies.

RESOLVED that the Safer Barnsley Partnership Plan for 2016–2020 be endorsed.

42 SEND Strategy (HWB.06.12.2016/9)

The meeting received a report on the aims and strategic priorities of the Borough's Special Educational Needs and Disability (SEND(D)) Strategy 2016-18. The Strategy set out a range of objectives within three priorities: Improving lifelong outcomes for Children and Young People with SEN(D) and their families; Involving, engaging and enabling those children, young people and families; and Ensuring the highest quality of provision and services through effective procurement and commissioning arrangements.

RESOLVED:-

(i) that the recent publication of the Strategy be noted and partners seek to adopt its broad aims and strategic priorities;

(ii) that any implications of the forthcoming Ofsted inspection of the Borough's SEN(D) provision in the Borough during 2016/17 and the proposals in the Education White Paper, published in March 2016, regarding the continuing role of local authorities and their partners in SEN(D) provision be the subject of further reports to the Board in due course.

43 Travel Assistance Policy (HWB.06.12.2016/10)

The meeting received a report on the draft Travel Assistance Policy, seeking to update the current Home to School Transport Policy. The revised policy focused particularly on promoting independence in how transport was provided or supported. Consultation with service users, residents and relevant stakeholders was currently

underway, with the intention of the updated policy being implemented from 1st April 2017.

RESOLVED that the report be noted.

44 Police and Crime Commissioners and Health and Wellbeing Boards (HWB.06.12.2016/11)

The meeting received a joint letter from the Home Secretary and Secretary of State for Health, highlighting some of the important benefits that could be realised through closer collaboration between policing and health partners. The meeting noted that the District Police Commander for Barnsley had been a member of the Health and Wellbeing Board since its inception, and reference was made to the consideration of the Safer Barnsley Partnership Plan earlier in the meeting as an example of joined up working in Barnsley.

RESOLVED that the letter be noted and the Home Secretary and Secretary of State for Health be advised of the position in Barnsley.

Chair

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Minutes of the Children and Young People's Trust Executive Group Meeting Held on 24 November 2016

Present:

Core Members:

Rachel Dickinson (Chair)	BMBC, Executive Director: People
Cllr Margaret Bruff	Cabinet Member: People (Safeguarding)
Julia Burrows	BMBC, Director of Public Health
Alicia Marcroft	BMBC, Head of Public Health
Bob Dyson	Independent Chair of the Barnsley Safeguarding Children Board
Mel John-Ross	BMBC, Service Director of Children's Social Care and Safeguarding
Gerry Foster-Wilson	Executive Headteacher representing Primary Schools
Tim Innes	South Yorkshire Police Chief Superintendent
Margaret Libreri	BMBC, Service Director for Education, Early Start and Prevention
Clare Bannon	Barnsley Local Medical Committee GP representative
Margaret Gostelow	Barnsley Governors Association Chair
Sandra Newman	Barnsley Hospital NHS Foundation Trust, Interim Head of Nursing and Midwifery

Deputy Members:

Sharon Galvin	Barnsley Clinical Commissioning Group, Designated Nurse Safeguarding Children/ Looked After Children (for Brigid Reid)
Kathryn Padgett	South West Yorkshire Partnership Foundation Trust (SWYPFT), Assistant Director of Nursing (for Dave Ramsay and Sean Rayner)
Ann O'Flynn	BMBC, Service Director Customer Services (for Wendy Lowder)

Advisers

Richard Lynch	BMBC, Head of Commissioning, Governance and Partnerships

In attendance

Liz Pitt	BMBC, Research & Business Intelligence Manager (for item 5)
Sara Hydon	BMBC, Head of IT (for item 6)
Julie Govan	BMBC Children's Social Care and Safeguarding Improvement Programme Manager (for item 11)
Denise Brown	BMBC, Partnerships and Projects Officer

			Action
1.	Apologies		
	Tim Cheetham	Cabinet Member: People (Achieving Potential)	
	Julie Green	BMBC, Strategic Lead, Procurement and Partnerships Manager	
	Sean Rayner	SWYPFT District Director Barnsley/ Wakefield	
	Wendy Lowder	BMBC, Service Director for Stronger, Safer and Healthier Communities	
	Jenny Miccoli	Barnsley College, Vice Principal Teaching, Learning and Student Support	
	Rubina Rashid	Barnsley College, Assistant Principal Students	
	Christine Drabble	Voluntary Action Barnsley, Chief Executive Corporate Services	
	Brigid Reid	Barnsley CCG, Chief Nurse	

		Action
	Anna Turner — BMBC School Models and Governor Development Manager Amanda Glew — BMBC Organisation Development Manager Dave Whitaker — Executive Headteacher representing Secondary Schools Rachel welcomed everyone to the meeting, particularly new colleagues, and stressed that this was a working meeting which encouraged respectful challenge to drive improved outcomes.	
2.	<u>Shared experiences from the front line</u> The following reflections from the front line were shared: • Margaret Libreri had visited new Acting Head Teachers in Primary Schools and had been impressed with the core work taking place, with the Head Teacher's knowledge of individual children and the support that the school had in place for them. It was evident that there was commitment to supporting vulnerable families. • Alicia stated that although the transition of the 0-19 Service had been challenging, staff felt welcomed, well supported and were looking forward to the service re-design. • The joint TEG/BSCB meeting had coincided with 'take over' day and officers who had been 'taken over' had brought the young people to the meeting. They made a fantastic contribution and their ability to speak so candidly to such a large audience was impressive. Strong messages were delivered which were both passionate and inspirational. • Rachel had been forwarded a copy of a heart-warming e-mail which had been sent to an Adoption Social Worker from an adopter to say how well they were doing. Rachel undertook to circulate the e-mail to members in recognition of the good work taking place and the impact on people's lives. Names would be changed to protect their identity.	Rachel
3.	<u>Identification of confidential reports and declarations of any conflict of interest</u> The Continuous Service Improvement Plan is to be treated as confidential. No conflicts of interest were declared.	
4.	<u>Minutes of the previous TEG meeting held on 6 October 2016</u> The minutes were approved as an accurate record of the meeting.	
4.1	<u>Action log</u> Outstanding actions were updated as follows: Item 9 – Consider impetus on cultural change for improving staff skills to deliver quality services. Ann O' Flynn stated that Jayne Hellowell is dealing with this action and it was presumed that an update would be brought to the next meeting. Item 6(i) – Early help All Age Strategy. It was noted that whilst there is a Children's early help strategy in place, an All Age Strategy is being developed which is scheduled to be completed in January.	Paul Hussey/ Jayne Hellowell

		Action
	Item 6(ii) - Universal information and advice. Ann stated that good progress is being made. A plan is being developed and this work will report into the Council's Customer Service Implementation Group. Funds have been obtained from the improvement and growth fund to recruit a project manager who will report to Ann O'Flynn. Rachel requested that TEG is informed if assistance is needed to progress this work. Actions outstanding from October 2016: Item 5(i) – Undertake a deep dive in relation to exclusions of pupil premium pupils and those with identified SEN. Margaret confirmed that a report from the Barnsley Alliance Board would be submitted to the January TEG meeting. It was noted that the Barnsley Alliance Board meeting once a term, and that the spring term meeting will focus on inclusion issues. Item 5(ii) – Challenge Secondary Schools to engage more with the early help offer. It was noted that the main initiators of EHAs are primary schools and family centres. Representatives from the early help service are going to arrange to attend a Secondary School Headteachers meeting in January to discuss the pathways and offer, and to consider how to monitor what targeted early help is in place in secondary schools. Item 5(iv) – Rachel stated that it had been agreed that a peer review on children missing education would take place in the spring of 2017 and that the results would be brought back to TEG. Item 11(i) – Children's Workforce Development. Tim undertook to obtain an update in relation to this action for Jakkie and Amanda to discuss training available. Item 11(ii) – Richard stated that he was working with Amanda Glew and Sue Price to put together a briefing for staff to help them to understand approaches to personalisation and to ensure that personal budgets are being promoted to parents and that they understand their rights to request a personal budget. Item 15(i) – Rachel stated that Barnsley Hospital NHS Foundation trust representation at TEG had not been brought to a conclusion yet.	
5.	<u>Joint Strategic Needs Assessment</u> (Liz Pitt) Liz provided an update which is summarised as follows: • The JSNA attempts to bring information into one place and will be updated on a regular basis. • It was noted that Barnsley's population is rising, particularly in the older age groups. • The JSNA focuses on health conditions experienced by Barnsley residents, including poor mental health and diabetes. • It includes engagement with services and customer feedback. • More detail is available in the bigger report which includes the facts and figures that sit behind the JSNA, including information relevant to Wards and Councils. • In the next few months a mapping exercise will be undertaken to reveal where the 'hotspots' are in Barnsley.	

		Action
	The following questions/ comments were raised: <u>Children in Care</u> It was noted that children in care are not specifically mentioned in the JSNA and Sharon Galvin pointed out that this is something that inspectors would ask about. Liz and Sharon agreed to work together to include this information. <u>JSNA and JSIA</u> Tim Innes queried the possibility of the JSNA and JSIA being merged. Liz explained that whilst there are links between the two documents they need to be kept separate. The JSNA is a public document which is focused on health, and needs to be continually updated, whereas the JSIA has a restricted audience, concentrates on crime and anti-social behaviour and is updated annually. Information in the evidence base links the two documents. Rachel stated that this had also been considered by the Senior Strategic Development Group who had concluded that whilst the two documents need to be in tandem their audiences are different. Liz undertook to circulate the link to the JSNA once it is accessible. Rachel stressed the importance of members making a commitment to use the data in the JSNA.	Liz/ Sharon Liz
6.	<u>Information Sharing</u> (Sara Hydon) Richard explained that this item had come out of a discussion at a previous meeting about the importance of sharing the right information and an acknowledgement that the systems in place don't always support that. It had been requested that Luke Sayers attend a TEG meeting to consider how information sharing could be improved between organisations, however Luke had since left the organisation and Sara was seeking further guidance about what was required and the type of information that needs to be shared. During the discussion the following points were noted: • A joint information management system needs to be developed. • A Public Services HUB is in the early stages of design by Jayne Hellowell (Communities). • Organisations are not using the same systems to allow access to each other's customer records. • There are systems in place in the health arena to allow access to patient's records, with their permission, but in some cases these systems are not being used. There is also mis-information for patients regarding who their information will be shared with – Sara explained this will need to change under the new Data Protection Act 2018. • It was acknowledged that creating a single data warehouse would be a massive project and it was suggested that a smaller piece of work be undertaken to scope out what immediate small steps could be taken to make it easier for practitioners. **It was agreed that:** • Kathryn would provide Richard with an update on a piece of work being undertaken by SWYPFT in relation to system management. • Sara, Alicia and Richard to consider the opportunities in the 0-19 Service. • The MASH would be the test-bed to identify the steps that could be	Kathryn Sara/ Alicia/ Richard

		Action
	taken. • A report would be provided by Sara and Richard at the next meeting.	Sara/ Richard
7.	<u>Children and Young People's Plan Monitoring Template</u> (Richard Lynch) The CYP Plan monitoring template aims to articulate those actions and progress measures against outcomes which the partnership agrees collectively to support. It is important to get a sense of what is happening and the progress being made. The responsibility of the identified TEG champions is to obtain progress against outcomes for reporting to TEG on a quarterly basis. Some of the information is provided in the performance reports and in the continuous service improvement plan. It was agreed that the first report would be submitted in January. *(Following the meeting it was agreed that it would be better to report into the TEG meeting on 3rd March, given that the Qtr 3 performance information would only be available in the first week of February)*. Julia pointed out that the 'Healthy Lifestyle Services' TEG Champion would be Alicia Marcroft, not Carrie Abbott. The following comments/ questions were noted: • Considering what the young people said at the joint TEG/BSCB meeting, Rachel queried whether the outcomes are still suitable and it was suggested that the TEG Champions discuss the outcomes with members of the Youth Council. • It was agreed that a revised version of the monitoring template would be developed to include the issues raised by young people and circulated for comment. • The Continuous Service Improvement Plan to be aligned with this work. • Mel undertook to work with Julie Green to ensure that the key messages are included in the notes of the joint TEG/BSCB meeting. • It was agreed that any additional feedback by the young people who had taken over roles in the 'take over' day would be relayed to Mel. • Rachel undertook to discuss with Matt Gladstone the points raised by young people in relation to transport, and to invite Matt to attend a future TEG meeting to report on what has happened as a result, which would be fed back to the Youth Council.	Work programme TEG Champions Richard/ Denise Mel/ Julie Green Rachel
8.	<u>CYP Trust Annual Report</u> (Richard Lynch) The draft CYP Trust Annual Report included introductory information which would be relevant for people outside of the CYP Trust, and reflected on key achievements and challenges. The following comments were noted: • Tim requested that more up-to-date information be included in the Community Safety Section of the report and undertook to ask Jakkie to provide a paragraph to be included. • The report needs to 'lay a path' to the next annual report. **It was agreed that:** • The MS word version of the report would be circulated for comment	Denise/

		Action
	and/or suggested amendments by 16 December 2016. • Unless there are any major amendments or challenges, the report is taken as signed off by the TEG.	Members
9.	<u>CYP Trust Website</u> (Richard Lynch) A refreshed CYP Trust website has been launched and includes: the Trust's vision, priorities and outcomes; a paragraph how children, young people and families are supported; a brief paragraph about TEG; dates of future meetings; and links to key documents. Links to the Health and Wellbeing Strategy and the Safer Communities Plan are still to be included. An enquiry form is available on the website to request past TEG minutes and meeting papers. It is proposed that another page be added to the website to include the CYP Trust Annual Report; quarterly progress reports towards achieving the objectives in the children and young people's plan via the agreed template; and the latest set of approved TEG minutes. It is also proposed that a link be provided to the video's prepared for the joint TEG/BSCB meeting. The following comments were noted: • It was agreed that it would be helpful to provide a link to the videos of young people being interviewed. • Particular caution will need to be taken to remove any confidential information from the minutes before publishing them on the website.	
10.	<u>Barnsley Safeguarding Children Board Meeting - 11 November 2016</u> (Bob Dyson) Bob highlighted the following issues that had been raised at the meeting: • The Toxic Trio Event held on 13 October had been well attended, and another event is being planned during Safeguarding Awareness Week in 2017. • Some agencies had been under the misconception that thresholds had changed and, as this is not the case, reassurance was given and the processes reinforced. • A discussion had been held regarding continued concerns about the levels of exclusions, and whether any cross checking takes place against children in care or children who have Child Protection Plans. It had been agreed that these concerns would be escalated to the Barnsley Alliance Board for a formal response. • The Section 175 Safeguarding Audit had achieved a 100% return this last academic year. The Early Years Team had agreed to undertake a safeguarding audit of about 200 settings and will be reported to a future meeting. • The MVCA Safeguarding Forum is attended by representatives of key agencies. Their aim is to identify the most vulnerable young people and to ensure that everything possible is done to support them. • Public Services Hub. A presentation was given on the proposed new model to support vulnerable people and manage demand on services. • FGM Strategy to be updated to include a section on enforcement and submitted to the Safeguarding Adults Board as a joint strategy for sign off. • A Neglect Strategy Task and Finish Group had been established and	

		Action
	it was agreed that on completion of the agreed tasks, a decision would be taken whether or not a sub-group of the BSCB is required. It was noted that <u>behaviour, attendance and exclusion</u> issues will be considered at the TEG meeting in January. A discussion followed which is summarised below: • There are links between exclusions and those with special educational needs. Schools who exclude pupils may achieve improved outcomes at the expense of the schools who are obliged to accept them. • There has been an increase in the number of young people being educated at home, but unless the parents' give their consent to a visit there is currently no way of ensuring those young people are being appropriately educated. Kathryn stated that in the new year NHS England are introducing standards which home educated children will be expected to work towards. • Some schools have adopted a scale of sanctions and nurturing, and have employed counsellors from MIND and their own Police Officers. Schools need to become more than just an educational establishment. • Secondary School systems can be very different to those in Primary Schools and, whilst every effort is made in all schools to improve attendance of vulnerable children, there is an increased risk that some vulnerable children will be excluded in Secondary School. • It is important for the school to take into account some of the challenging home environments that children come from and to do everything possible to ensure that children are not excluded. • It was noted that schools are encouraged to put appropriate provision in place for the children in their school, and that protocols are in place to keep managed moves between schools to a minimum. • School Nurses need to ensure that they don't lose sight of those young people whom they have not seen for a while. It was agreed that, following the TEG meeting in January, the information provided to consider the issues around behaviour and attendance would also be presented to the Barnsley Alliance Board and utilised by the working group to improve this outcome. It was further agreed that an item would be put onto the Primary Head Teacher's agenda.	Margaret Libreri Margaret Libreri
11.	<u>Continuous Service Improvement Plan</u> (Julie Govan) Confidential Following the joint TEG/BSCB meeting the Continuous Service Improvement Plan is being revised and would be available at the next TEG meeting. New sections in the plan include substance misuse, mental health and fostering. It had also been agreed that consideration be given to having a peer challenge by Board Members around an area of interest to validate progress to date and the outcomes around each of the different sections. This will be reflected in the minutes of the joint meeting. RAG rating the key outcomes/elements in the plan will help the CYP Trust to focus on the right areas and will also help with preparation for the	Julie Govan Julie Green

		Action
	Ofsted Inspection. It was agreed that the Continuous Service Improvement Framework would be circulated for comment with a deadline of 30 November, and issued from 1 December. Work on the story boards is ongoing.	Mel/ Denise
12.	TEG Work Programme (Richard Lynch) The TEG work programme has been distributed to everyone who has an allocated item on the programme. Members were asked to submit any comments or amendments to Richard Lynch.	Members
13.	Any Other Business Use of Modern.gov to create agenda packs It was agreed that the agendas would continue to be created using the Modern.Gov application and posted to the website, but also circulated as an attachment to an e-mail. It was also agreed that reports that are confidential will be indicated as such in the pack, and that there is no need to create a supplementary agenda or to use Egress to e-mail the agenda. Membership It was noted that this was Clare Bannon's last meeting before going on maternity leave, and Rachel thanked her for her valuable contribution to TEG and wished her all the best for the next year. Dr Jamie MacInnes would be attending TEG meetings from January as a GP representing both the CCG and the Local Medical Committee.	

Proposed agenda items for next meeting on 20 January 2017

1. Barnsley Safeguarding Children Board Minutes – highlights (Bob Dyson)
2. Continuous Service Improvement Plan – confidential (Julie Govan)
3. TEG Work Programme Review
4. CYP Plan monitoring
5. Strategic Priority Theme: Improving staff skills to deliver quality services – report on performance measures to monitor/ challenge; provide updates into TEG; highlight where there are problems or risks (Amanda Glew)
6. Vulnerable children with SEN/ SEND Report (Margaret Libreri)
7. Access to therapeutic support and waiting times (Brigid Reid)
8. Inclusion and vulnerable groups (Matt Orr)
9. Looked After Children Sufficiency Strategy/ Foster Carer Placements (Richard Lynch) Action focused discussion re. how to collectively secure more foster carers in Barnsley
10. Healthy Start 0-19 (Public Health/ Kay Bennett)
11. Stronger Communities Partnership (Paul Hussey)

Items to discuss SEND and the 'deep dive' on attendance issues are key.

Barnsley Community Safety Partnership
Executive Group meeting

BARNSLEY COMMUNITY SAFETY PARTNERSHIP
EXECUTIVE COMMITTEE MEETING MINUTES

Wednesday, 23rd November, 2016
10:00am to 12:00am
Westgate Level 3 Boardroom

Present:
Wendy Lowder, Barnsley Council Tim Innes SYP (Chair) Melanie Fitzpatrick, Barnsley Council Jason Pearson, SYP John Hallows, Barnsley Neighbourhood Watch Liaison Group Jayne Hellowell, Barnsley Council Julie Mitchell, SYP Paul Hussey, Barnsley Council Ben Finley, Barnsley Council Stephen Carroll, SY CRC Mel John-Ross, Barnsley Council Councillor Jenny Platts – Barnsley Council Cheryl Wynn – Police & Crime Commissioners Office Robert Frost – Barnsley Council Carrie Abbott – Barnsley Council Steve Fletcher – SYFR Lorna Naylor, BMBC (Minutes)

Introduction - Chair
The Chair welcomed everyone to the meeting and introductions were made.
1. Apologies
Apologies were received from Dave Fullen, Ann Powell, Linda Mayhew, Councillor Alice Cave, Paul Brannan, Jakki Hardy, Shelley Hemsley and Robin Pearson.
2. Minutes of Previous Meeting
The minutes of the meeting of 12th September 2016 were agreed as a true record. *Action Schedule* Item 1.1 – CCTV Information Sharing Agreement (ISA) With regards to the ISA for the Town Centre CCTV systems, a Service Level Agreement between Barnsley MBC and South Yorkshire Police has been developed.

Barnsley MBC has drafted an ISA for the sharing of information from the traffic cameras which is currently being considered for implementation.

A report was requested for presentation at the next Board meeting providing an overview of the CCTV systems in operation across Barnsley and the agreed governance arrangements.
Action : Paul Brannan / Jakki Hardy / Liz Blackburn to meet and present a CCTV overview report including governance arrangements at the next meeting.

Item 2.1 – CSE Safeguarding

Ben Finley/Paul Brannan have met and progress has been made with regards to addressing issues with some accommodation providers within Barnsley where other Local Authorities are placing young people and ASB is a concern. Mel-John Ross informed the meeting that Safeguarding have requested to be informed when placements from outside the area are arriving in Barnsley.
Action : Ben Finley to provide a further update at the next meeting regarding progress with accommodation providers and current approaches/agreed protocols.

Item 6 – Information Sharing Protocol (ISP)

Mel Fitzpatrick informed the group that meetings have been arranged with Barnsley Hospital NHS Foundation Trust and the South West Yorkshire Partnership NHS Foundation Trust to negotiate their sign-up to the ISP. A further update to be given at the next meeting.
Action : Mel Fitzpatrick to provide a further update regarding the Safer Barnsley Information Sharing Protocol at the next meeting.

Item 9 – Self-assessment – night time economy

Diane Lee has now completed the presentation on the findings of the self-assessment; the Chair asked if the presentation could be given to the next meeting.
Action : Diane Lee to be invited to deliver the Night Time Self-Assessment presentation at the next meeting.

All other actions on the schedule were discharged or covered on the agenda.

3. Public Services Hub Update – Jayne Hellowell

Jayne Hellowell gave a presentation on behalf of BMBC and SYP on the development of with the Public Services Hub. The future operating model is currently being developed and will be in place by April 2017.

Tim Innes thanked Jayne for the presentation adding that there is an opportunity for other agencies to get involved and pool resources to deliver services for Barnsley.

SYFRS, the CRC and Neighbourhood Watch all supported the development of the hub and expressed an interest in contributing to the shaping and delivery of the future operating model.

Wendy Lowder added that links with the Stronger Communities Partnership are also being further developed.

Jayne Hellowell informed the meeting that a Project Manager, Fiona O'Brien, has been appointed to lead on the project. Fiona will make links with the Stronger Communities Partnership, Voluntary Sector, Fire Service and CRC.

Action : Fiona O'Brien/Jayne Hellowell/Jakki Hardy to arrange to meet with the CRC, SYFRS, Stronger Communities Partnership, Neighbourhood Watch and the broader community and voluntary sector.

4. JSIA Presentation – Jason Pearson

Jason Pearson gave a presentation on the JSIA for 2016/17. The Summary document will be circulated to all members. Jason confirmed that the key findings of the document reflect the priorities set out in the Safer Barnsley Partnership Plan (2016-2020) and that further work would be undertaken with the three Priority Sub-Groups in relation to the further development of regular tactical assessments to inform the work of the sub-groups and the deployment of resources.

Tim Innes thanked Jason for the presentation.

Action: Jason Pearson to circulate the summary JSIA document to all Board members.

5. CSP Governance Review & Refreshed Terms of Reference – Paul Hussey

The refreshed Terms of Reference for the CSP Partnership Board and Strategy and Performance Group were shared with the group.

The aim of the Board will be to focus on strategic issues and links across the partnership landscape. The Strategy and Performance Group will provide the link between the strategic board and the tactical/operational groups. There will be 3 Priority Sub Groups (Protecting Vulnerable People, Tackling Crime & ASB and Promoting Community Tolerance and Respect) whose role will be to operate at a tactical level, and use problem solving approaches to deliver the agreed community safety strategic priorities and outcomes. A further operational tier of task and finish groups will be established to meet as and when required to support the delivery of the Partnership priorities and outcomes.

A performance framework is currently being developed to align with the three high-level community safety strategic priorities.

Paul Hussey advised that the first meeting of the Strategy and Performance Group took place on 17-11-2016. The notes from the meeting will be circulated for information.

Paul thanked the Priority Leads for their input into the new governance arrangements and agreed that a further update will be brought to the Board in March 2017. Board Members were asked to forward are any comments in relation to the new Terms of Reference to Melanie Fitzpatrick by 9th December, 2016.

Action : Any comments on the Terms of Reference to be forwarded to Mel Fitzpatrick by 9-12-16. A further report on the CSP Governance Review to be scheduled for the Safer Barnsley Partnership Board in March 2017.

6. Crime Performance Overview

Jason Pearson provided a brief overview of crime in Barnsley. He highlighted that vehicle crime has seen an increase, in particular theft of and theft from Ford Transit vans. An operation by SY Police is being introduced to tackle the problem, which will focus on prevention, intervention and enforcement. He also advised that Arson has seen an increase and that key hotspots have been identified across the borough and tactical plans are in place to address the issues. Hate crime has also seen an increase which has coincided with the recent hate crime awareness week.

7. Forward Plan – Wendy Lowder/ Tim Innes

Wendy Lowder presented the forward plan for 2016/17 and highlighted that this will remain a live document which can be amended to reflect emerging risks and priorities. Members were asked to consider the plan and inform Mel Fitzpatrick of any requested additions or amendments.

Action : Members to provide any comments / updates in relation to the Forward Plan to Mel Fitzpatrick.

8. County wide CSP Forum Update – Wendy Lowder

Wendy Lowder informed the group that the main items discussed were :-

Modern Slavery, the domestic abuse perpetrator scheme, OPCC resources.

9. Future Operations / Events

No specific operations or events were raised.

11. Any Other Business

Carrie Abbott informed the meeting that Barnsley has submitted a Local Alcohol Area Action bid. The bids covers two areas of work in relation to the Town Centre those being; economic growth and night time economy. Two key projects have been identified with an overall aim of reducing alcohol related violent crime those being a Door Staff engagement programme and improving the use of data to inform the identification of hotspots and resource deployment.

Members were asked to note that the submission does not bring any additional funding and that the outcome of the bid should be known around Christmas.

Cheryl Winn informed the meeting that the OPCC are hosting a SY Victim and Witness Showcase event on 9-12-16. Cheryl will forward details of the event to all members.

Action : Victim and Witness Showcase Event details to be circulated.

Steve Fletcher from SYFRS informed the group that consideration is being given to relocating Barnsley Fire Station.

12. Date and Time of Next Meeting
The next meeting will be held on **Monday 27th March 2017, at 1pm to 3pm in Silver Suite at Barnsley Police Station.**

Barnsley Community Safety Partnership
Executive Group meeting

Action schedule from minutes (23rd November 2016)

1	**Action schedule 12th September 2016**
1.1	CCTV ISA - Paul Brannan/Jakki Hardy/Liz Blackburn to meet and present a CCTV overview report including governance arrangements at the next meeting.
1.2	CSE Safeguarding - Ben Finley to provide a further update at the next meeting regarding progress with accommodation providers and current approaches/agreed protocols.
1.3	Partnership Information Sharing Protocol - Mel Fitzpatrick to provide a further update regarding the Safer Barnsley Information Sharing Protocol at the next meeting.
1.4	Self-assessment - night time economy - Diane Lee to be invited to deliver the Night Time Self-Assessment presentation at the next meeting.
2	**Public Services Hub Update**
2.1	Fiona O'Brien/Jayne Hellowell/Jakki Hardy to arrange to meet with the CRC, SYFRS, Stronger Communities Partnership, Neighbourhood Watch and the broader community and voluntary sector.
3	**Joint Strategic Intelligence Assessment**
3.1	Jason Pearson to circulate the summary JSIA document to all Board members.
4	**CSP Governance Review & Refreshed Terms of Reference**
4.1	Comments on the Terms of Reference to be sent to Mel Fitzpatrick by 9th December, 2016.
4.2	A further report on the CSP Governance Review to be brought to the meeting in March 2017
5.	**Forward Plan**
5.1	Members to provide any comments / updates in relation to the Forward Plan to Mel Fitzpatrick.
6.	**Any other Business**
6.1	Details of the Victim and Witness Showcase Event on 9-12-16 to be circulated.

Health and Well Being Provider Forum

Minutes of the meeting held on Wednesday 7 December 2016

Present

Helen Jaggar	Berneslai Homes (Chair)
Pauline Kimentas	Age UK
Andrew Pearce	Caremark
Zoe Oldfield	SYHA
Richard Walker	TLC Homecare
James Barker	Barnsley Health Care Federation

	ACTION
Item 1 – Apologies Apologies were received from Sean Rayner, SWYPFT; Michelle Hall, Mencap; Julie Ferry, Barnsley Hospice; Age UK; Anne Simmons, Alzheimers; Phil Parkes, SYHA; Carolyn Ellis, VAB; Kevan Riggett, BPL; Jo Clarke, CAB; Sam Higgins, Phoenix Futures	
Item 2 – Minutes of meeting held 14 September 2016 Agreed as an accurate record. **Matters arising** Item 7 – Barnsley Strategic and Operational Intelligence Group – as this group are reviewing the Joint Strategic Needs Assessment (JSNA) the Forum had previously requested an update. HJ reported that the JSNA had been tabled at the Health and Wellbeing Board on 6/12/16 and will be placed on the Council's website. Data has started to show issues for Barnsley. Identified variety of lifestyle choices that impact on health such as smoking, excess weight, alcohol, inactivity, unhealthy eating. The key headlines within the assessment will be factored into various strategies and the Barnsley Place Based Plan. The forum felt it would be beneficial to view the Plan therefore it was agreed to include the link to this Item 3 – Health and Wellbeing Board - noted that Public Health have action plans in place to tackle oral health, suicide prevention and a smoke free generation and the forum have requested that a representative be invited to future meetings to speak on these. Oral health to be tabled at the meeting on 7th March 2017. Item 5 – Flu Immunisation Presentation – Tracey Turner, Screening and Immunisation Co-ordinator had fed back to SSDG the issue raised by the Forum with regard to consideration of the funded immunisation programme being extended to Care Providers and also raised the investment to save aspect, however position will remain as is.	

Item 3 – Health and Wellbeing Board HJ provided an update from the two meetings held since the last meeting of the Forum. 4 October 2017 – main issues considered were the Health and Wellbeing Strategy which the Board has now approved (link to strategy below). Key areas identified for improvement being; improving outcomes for children and young people; reducing smoking; improving early help for mental health and join up of services for older people. The Strategy also recognises the different areas of need across the borough. The Council are aiming to make this a more accessible document so members of the community will read this. https://www.barnsley.gov.uk/media/4161/barnsleys-health-wellbeing-strategy-pdf-final.pdf 6 December 2017 – main issues considered were sign off of the JSNA and Sustainability and Transformation Plan which has been published and identifies a £571 m. financial gap. There are 8 priority areas which will be focussed on. High level consultation has taken place and further fuller consultation will take place on specific proposals arising from the Plan. The Forum felt that they needed to fully understand the implications/delivery of the Plan as there may be an opportunity for providers to contribute to shaping the services within this going forward. Following discussion it was felt the providers main focus should be input/understanding and fit within the Barnsley Place Based Plan/Action Plan as this will determine the delivery process for Barnsley. It was agreed therefore to invite a representative to the March meeting to discuss this further.	
Item 4 – Stronger Communities Partnership Due to apologies PP had provided a paper (embedded below) which gave an update on the Stronger Community Partnership Board meeting held on the 22 November 2016. Key points of interest for the forum were in respect of Early Help Adults and Children. PK/JC had attended initial meetings of the Early Help Adults Group where work is currently taking place on KPIs which will be included in a high level Action Plan. The forum felt it would be useful to look at the objectives of the Action Plan. Agreed that forum representatives should provide a written summary from the groups to future meetings of the forum. **Item 5 – Social Prescribing – My Best Life** Zoe Field, Enterprise Programme Manager, SYHA gave a presentation on the Social Prescribing Model (slides embedded below). The aims of	**PK/JC/ SH**

the service, structure and associated timelines to the project commencing in Barnsley from April 2017 were highlighted and discussed. The key issue raised by the Forum was in relation to the referral route and whether this could be widened and the barriers to early help and prevention. ZF stated that the referral route is predominantly through GP's at the present time. Due to the feedback from the forum on this particular issue it was proposed that ZF raise with PP whether a provider could have membership on the Steering Group during the pilot period. RW said he would represent the forum if this was agreed. In respect of community mapping at local neighbourhood level PK felt it may be useful to consider what is taking place in Penistone and any linkages to this. HJ requested that if any home health checks take place in Council properties that Berneslai Homes be notified to avoid any duplication. The discussion also highlighted the many different strategies and linked services that fall under the wellness theme and the forum felt it would be beneficial for providers and customers to have a single page document that identified each of these. HJ agreed to raise at SSDG.	**PP** **HJ**
Item 6 – Future Agenda Items 8 March 2017 Oral health – Public Health Barnsley Based Place Plan – Jade Rose, Head of Commissioning for Integration and Partnership 14 June 2017 Universal Information & Advice /Live Well Barnsley – K. Dodd	
Item 7 – Date of next meeting – 8 March 2017 at Berneslai Homes, Gateway Plaza at 10.00 a.m.	
Item 8 - Universal Information & Advice /Live Well Barnsley – the workshop to be facilitated by K. Dodd was deferred to 14 June due to apologies.	
Item 9 – Any Other Business **i.** PK reported that Age UK had been award a contract by Penistone Area Council on social isolation and vulnerable people in the area. Providers were asked to to note this if working with people in this locality. Contract to commence on 15/1/17. PK to provide further information in due course. **ii.** Reported for information that K. Dodd had been undertaking work on digital skills for people with dementia. BMBC and Berneslai Homes have also been holding Device Doctor sessions in community centres/sheltered schemes which encourage people to go on line. L. Taylor, Digital Development Manager, BMBC has been working on a project at Cherry Tree Court Care Home doing digital skills for people with dementia that has had a significant impact on health and wellbeing outcomes.	**PK**

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BARNSLEY METROPOLITAN BOROUGH COUNCIL
COMMUNITIES DIRECTORATE

STRONGER COMMUNITIES PARTNERSHIP
TUESDAY, 22ND NOVEMBER, 2016

Attendees:-
Councillor C Lamb, BMBC (Chair)
Councillor J Platts, BMBC
Wendy Lowder, BMBC
Keith Dodd, BMBC
Jacqui Bradley, BMBC – Minute Taker
Margaret Libreri, BMBC
Paul Hussey, BMBC
Lennie Sahota, BMBC
Carrie Abbott, BMBC
Lisa Wilkins, BMBC/CCG
Gill Stansfield, CCG
Dave Fullen, Berneslai Homes
Christine Drabble, VAB
Adrian England, Healthwatch
Phil Parkes, SYHA
Marie Hoyle, Practice Manager, Kakoty Practice
Ann Simmons for item 5

Apologies:-
Carrie Abbot is now the rep for Public Health
Dave Fullen is now the rep for Berneslai Homes
Jade Rose, CCG
Gill Stansfield is now the rep for SWYPFT
Chris Millington, CCG

MINUTES

1 **Welcome and Introductions**

(a) **Declarations of Interest**

None

(b) **Minutes of Last meeting**

Page 1
- The list of attendees to be amended to say Julia King and not Julie Keane.
- Councillor Platts asked for an amendment to be made to paragraph 5. The sentence refering to Bright House is incorrect as they are still selling white goods.

Page 3
- paragraph 4 Julia King's name to be added to replace Julie Keane's
- item 4 – Lisa Wilkins asked for the second sentence to be changed to say 'different programme areas'

Actions: Jacqui Bradley

Item 7 - Falls - Adrian England reported that he hadn't received the consultant's report. Keith Dodd agreed to check and resend it.

Action: Keith Dodd

(c) **Action Log**

Social Prescribing – Lisa Wilkins reported that work is scheduled to start on the six areas identified from 1st April, 2017.

Christine Drabble confirmed that the VAB pilot will continue until the end of March 2017

Marie Hoyle reported on a Health Champions event taking place on 6th December 2016 and a social prescribing training session on 7th February 2017.

Councillor Lamb asked for a progress update to be given to the next meeting.
Action: Phil Parkes

Wendy Lowder reported that she is meeting with Jane Williamson (Northern College) on 5th December to discuss progress on mapping Peer Support.

Phil Parkes confirmed that Building Better Opportunities is progressing and they will shortly be recruiting to posts.

2 **Progress Updates**

(a) Adults Group

Paul Hussey reported that the delivery plan has been agreed and circulated to all partners and stakeholders. Work is progressing on the performance dashboard. He thanked all partners and stakeholders for their involvement.

Membership of the group has increased and the first workshop-type meeting was well received. It has been agreed that the Universal Information and Advice work stream will sit under the governance structure of the Customer Services Implementation Programme Board.

Paul explained that there are five objectives within the Delivery Plan:

- Reviewing and revising the Independent Living offer
- Building the capacity of the Voluntary, Community and Social Enterprise Sector (VCSE)
- Integrated living for vulnerable people
- Older people
- Health and housing

Paul provided an update on progress under each objective

Questions:-

Data sharing was raised and a discussion followed about how existing systems could be integrated with a common view that quite a lot of pace has been lost on this in recent times with all of our collective restructuring.

Wendy Lowder agreed to speak to the Council's IT section about ERICA and data sharing with NHS colleagues.

Action: Wendy Lowder

(b) Anti-Poverty Group

Councillor Platts gave an update and reported that the CCG, Credit Union and Schools Alliance do not regularly attend the Group.

The Benefit Cap Task Group action plan has been completed. Sessions to offer advice and support by partners have been offered but attendance by those likely to be affected by the cap

has been poor. The Think Family Employment advisers are visiting some families to offer advice and support.

A second community shop has opened in Athersley.

Links to the Child Poverty Campaign led by Dan Jarvis MP have been established – Dan Jarvis's PA now attends the group.

(c) Children's Group

Margaret Libreri reported that the steering group continues to progress well. The referral pathway is much clearer than it used to be and the interface between early help services and social care has improved. Where there are borderline cases there is greater clarity on the actions that need to be taken.

Performance management has been challenging but sessions are being scheduled to finalise.

3 **SCP Delivery Framework**

Keith Dodd presented a programme plan for the partnership setting out the key deliverables and milestones.under each theme area.

The plan had three key purposes:

- To enable SCP members to have sight of the full programme of activity
- To enable SCP members to manage progress and stimulate further activity where there may be gaps in the programme
- To enable SCP members to communicate the business of the partnership with their staff and partner organisations

Members were asked to consider the plan for gaps, omissions and errors.

Delivery Group leads were asked to begin to extend their planning into the next financial year so that the plan could be updated for the next SCP meeting

Action: Keith to liaise with DG leads to update the programme plan

Lisa Wilkins referred to the need to ensure that the plan is aligned with requirements set out in the Barnsley Place Based Sustainable Transformation Plan (STP)

4 **Re-organisation of Community Nursing Services**

Gill Stansfield gave a presentation setting out how Community Nursing Services have been revised in response to the NHS Five Year Forward View. The future service will be aligned with the Area Council's boundaries, promote integrated working and focus more on the principles of self-management.

Following the presentation the Partnership agreed that they can offer support by ensuring services and teams across the community are all working together. Electronic systems also need to be joined up so they are accessible across the Partnership.

Wendy Lowder reflected with everyone in the room that we are collecting redesigning services with a much stronger focus on 'Place based' approaches which will enable us to build collective leadership at a place level across different organisational boundaries.

All agreed this was indeed the shared approach and felt that in doing so we could reclaim old ground that was felt to have been lost through strengthening cross organisational working.

Wendy muted the idea of testing out 'Place Based' conferences during 2017 – this was agreed as a useful approach and something we could all sign up to.

5 **Early Help for People with Dementia**

Ann Simmons gave a presentation on the work the Barnsley Dementia Action Alliance are doing to support those people within the Borough living with dementia, by encouraging communities to be more dementia friendly and enabling people to become Dementia Champions to assist those who need it.

The Dementia Action Alliance was established in 2012 and meets bi-monthly. 90 members have registered so far.

Following the presentation, the Partnership acknowledged that they can help to promote their work across the Borough.

Wendy Lowder suggested that Ann contact the Council's Communications Team – Emily Beevors to assist her in promoting the programme.

Action: Ann Simmons

Action : Keith to circulate the presentation to key others to assist this work.

6 **Future Meetings – Invitation to Submit Items**

Councillor Lamb asked colleagues to put forward items for discussion at future meetings. They should contact Keith Dodd in the first instance so that items can be added to the agenda.

Action: All

Dave Fullen referred to the impending changes to the welfare reform agenda, including the roll out of universal credit. Barnsley is in the first wave with the changes being introduced in July 2017. He asked for an item to be included on a future agenda so these can be discussed.

Action – Dave Fullen/Keith Dodd

7 **Any Other Business**

Wendy Lowder reported on two sub-regional bids that will be submitted shortly – one for rough sleepers, and a homeless prevention trail blazer for 14-21 year olds.

The Council is also planning to pilot Crowdfunder.

8 **Date and Time of Next Meeting**

Tuesday, 14th February 2017 at 1.30 pm at Shaw Lane

REPORT TO THE HEALTH AND WELLBEING BOARD

31st January 2017

SUICIDE PREVENTION

Report Sponsor: Julia Burrows
Report Author: Rebecca Clarke
Received by SSDG: 12 September 2016
Date of Report: 17 January 2017

1. Purpose of Report

1.1. To provide members with an overview of the latest cross-government suicide prevention strategy and an update in local suicide prevention work in Barnsley.

2. Recommendations

2.1. Health and Wellbeing Board members are asked to:-

- Note the progress so far on suicide prevention work.
- To support the development of the suicide prevention action plan

3. Introduction/ Background

3.1 Suicides are not inevitable. They are often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This can only be done by working collaboratively across all sectors. Suicide causes much distress to the families and friends affected and this is one of the key areas for consideration in suicide prevention.

3.2 Suicide prevention is one of the indicators in the Public Health Outcomes Framework and so it falls under the strategic responsibility of the Director of Public Health.

3.3 The All Party Parliamentary Group (APPG) on Suicide and Self-harm published an "Inquiry into Local Suicide Prevention Plans in England" in January 2015. The APPG considered that there were three main elements that are essential to the successful implementation of the national strategy for suicide prevention. All local authorities must have in place:

- Suicide audit work to understand local suicide risk
- A suicide prevention plan in order to identify the initiatives required to address local suicide risk

- A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local action plan.

3.4 The third progress report of the cross-government suicide prevention strategy was published on the 9th January 2017. The strategy details the activity that has taken place across England to reduce deaths by suicide. This report is being used to update the 2012 suicide prevention strategy in 5 main areas:

- expanding the strategy to include self-harm prevention in its own right
- every local area to produce a multi-agency suicide prevention plan
- improving suicide bereavement support in order to develop support services
- better targeting of suicide prevention and help seeking in high risk groups
- improve data at both the national and local levels

3.5 These updates will help to meet the recommendations of the Five Year Forward View for Mental Health relevant to suicide prevention: to reduce the number of suicides by 10% by the year ending March 2021 and for every local area to have a multi-agency suicide prevention plan in place by the end of 2017

4. Local work

4.1 A Barnsley Suicide Prevention Group has been established and is led by Public Health. The group has representation from Barnsley Council, South Yorkshire Police, NHS agencies, Samaritans and Citizens Advice.

4.2 The need to undertake a suicide audit for Barnsley, to provide more up to date intelligence on the factors affecting suicide in Barnsley, was agreed by the Barnsley Suicide Prevention Group in November 2015.

4.3 The aim of the audit was increase understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention. The audit has been carried out based on data was gathered from files available from HM Coroner's Office based in Sheffield. Records were accessed for all Barnsley residents who had received a Coroner's verdict of 'took his own life', 'took her own life' or 'suicide' in the latest five year (2010 to 2015) period of available data.

4.4 While the audit was limited to some extent by available records, it does provide a picture of suicide in Barnsley today. The audit report provides the evidence for the challenge of tackling suicide in the borough through an action plan, which will be agreed and prioritised by key stakeholders.

4.5 Linkages are being made to the Sustainability and Transformation Plan Mental Health work stream, the Mental Health Crisis Care Concordat, development of the Barnsley All Age Mental Health and Wellbeing

Commissioning Strategy and work across the distributed model of public health.

4.6 Suicide prevention is being considered as part of the priorities and task groups in relation to the development of a Mental Health Alliance.

5. Conclusion/ Next Steps

5.1 A Barnsley Suicide Prevention Action Plan has been developed in line with the national suicide prevention strategy and in response to the audit findings. This is a working document and iterative process changing to adapt to national policy and local need.

5.2 The Action Plan will be discussed and reviewed by the members of a revised Suicide Prevention Group.

6. Financial Implications

6.1 No financial have been identified in relation to this report, however implementing some of the actions in the suicide prevention action plan will have financial implications, for example supporting Mental Health First Aid (MHFA) training and campaign materials. Financial support is being sought from a number of sources including via the Sustainability and Transformation Plan process.

7. Consultation with stakeholders

7.1 The action plan has been consulted on with key partners.

8. Background Papers

8.1 The All-Party Parliamentary Group (2015) Inquiry into Local Suicide Prevention Plans in England
http://www.samaritans.org/sites/default/files/kcfinder/files/APPG-SUICIDE-REPORT.pdf

HM Government (2017), Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf

Officer: Rebecca Clarke Contact: rebeccaclarke@barnsley.gov.uk
Date: 17 January 2017

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Appendix 2

‘Future in Mind’
Barnsley
Transformation Plan

for

Children and Young People’s
Mental Health & Emotional Well Being

2015 - 2020

REFRESH

October 2016

CONTENTS

1. EXECUTIVE SUMMARY

Barnsley has welcomed the opportunities provided by the additional national resource supporting the Future in Mind recommendations and are utilising the whole of this resource to impact positively on the emotional health and wellbeing of children and young people and their families. We have entered the second year of this 5 year transformation plan to improve the emotional health and wellbeing of children and young people in Barnsley and this is the first annual refresh of the 5 year local transformation plan (LTP).

A Future in Mind Stakeholder Engagement Group has been established, consisting of a wide range of key stakeholders, who have worked tirelessly and enthusiastically together to implement the agreed priorities within the original transformation plan and to further develop the plan to significantly improve the outcomes for the children and young people of Barnsley over the next 5 years and beyond.

This refreshed transformation plan has been developed with all partners through the Barnsley Future in Mind Stakeholder Engagement Group. Children and young people represent themselves as part of this group. Barnsley's transformation plan continues to build on the existing knowledge and expertise within its services whilst also acknowledging the key challenges still faced within the areas of workforce, funding and data capture and utilisation. Importantly however, prevention and early intervention remain at the heart of the transformation.

The focus of transformation work in Barnsley continues to be to provide support to children and young people at the earliest possible time to prevent escalation of their problem(s) and to support their emotional health and wellbeing throughout their childhood and adolescence. This is exemplified by the fruition of two key programmes of work in the first year:-

- a school-led therapeutic team, now known as **'4:Thought'** aimed at 11 – 18 year olds
- the implementation of the **THRIVE** resilience programme for 5 – 11 year olds.

Services are being planned and will be provided in a multi-disciplinary way with all partners involved in the care pathway – with universal and early help practitioners being empowered to support children and young people with their emotional health and wellbeing needs through training, clinical support and oversight.

Through the Stakeholder Engagement Group it has been recognised that better links could be developed with Barnsley's Early Help offer and these links are now in the process of being formed.

The outcomes that will be delivered by the implementation of the transformation plan, driven by the Children and Young People's Trust, will enable the children and young people of Barnsley to be more emotionally resilient and effectively supported to prevent reduced prevalence of escalation of any mental health problems they may have.

The enhancement of the key prevention work and early years support that is being delivered by implementation of this transformation plan is fundamental in successfully supporting specialist services by enabling a sustainable reduction in demand, creating capacity and capability within the whole system.

2. STRATEGIC CONTEXT

Children and Young People's Mental Health forms an essential part of Barnsley's Health and Social Care priorities. The opportunities derived from the national resource is enabling Barnsley to respond positively to the challenges outlined in Future in Mind.

Mental health problems in children are associated with educational failure, family disruption, disability, offending and anti-social behaviour which places demands on social services, schools and the youth justice system. If mental health problems are left untreated, it can create distress in the children and young people, as well as their families and carers, continuing into adult life and affecting the next generation.

Barnsley has developed an 'All-age Mental Health and Wellbeing Commissioning Strategy' providing an umbrella for the work on children and young people's mental health. The Transformation plans are pivotal to successfully improving the outcomes for the children and young people of Barnsley.

Building resilience within our children and young people to enable them to enjoy robust mental health and wellbeing or to intervene early to prevent escalation of mental ill health are at the core of our transformation plans. The cost benefit of early intervention, particularly early in an infant and parent relationship, is obvious, and although it takes time, is a focal point of our plan.

3. EVIDENCE OF NEED - LOCAL CONTEXT

This section presents an analysis of the emotional health and wellbeing needs of Barnsley undertaken by Public Health. It highlights the most detailed and recent mental health data available including our Joint Strategic Needs Assessment and the latest ChiMat child health and CAMHS profiles. Local data however tends to be limited and is often generated as estimates from national survey intelligence or identified through NHS Digital.

Population

There are 54,900 children and young people aged 0 – 19 living in Barnsley (table one). This is 23.3% of the total Barnsley population (235,800).

The number of children and young people (0 – 19 years) is predicted to increase by 4.5% to 57,390 by 2020.

Currently 6.7% of school children in Barnsley are from an ethic minority heritage.

Table one Number of Children and Young People Living in Barnsley

	Barnsley	**Y&H**	**England**
Age, 2013			
0-4	14,600 (6.2%)	(6.3%)	(6.3%)
0 - 19	54,900 (23.3%)	(24.0%)	(23.8%)
0-19 projected 2020	56,200 (22.9%)	(23.6%)	(23.6%)
School children from ethnic minority groups, 2014	1,794 (6.7%)	(22.3%)	(27.8%)

Numbers of Children in Care

Barnsley has seen a recent increase in the numbers of looked after children (301 as at September 16) although this increasing trend has now levelled. Children out with the borough continue to be placed in Barnsley.

Determinants of health that may impact on the emotional health and wellbeing of children (or be affected by mental health)

Child poverty and deprivation is one of the most important factors determining health inequalities in childhood and throughout life. Research demonstrates that a child's physical, social and cognitive development during the early years strongly influences their school readiness and educational attainment, their employment chances and general health and wellbeing outcomes through to adulthood and older age.

There is often a complex/cyclical relationship between determinants of health and mental health with exposure to adverse environmental, social and educational conditions leading to increased risk of emotional and wellbeing issues but also that mental health problems can in themselves lead to subsequent deterioration of a person's social, educational, employment and housing conditions.

For children and young people the health and social wellbeing of parents and the family as a whole may impact on a child's or young person's emotional health and wellbeing.

Compared to England, in Barnsley the Public Health Outcome Framework, PHE Health Profile and Children's profile for Barnsley shows that:-

- **Deprivation**

  The indices of Multiple Deprivation (IMD) 2015 is the official measure of relative deprivation for small areas in England. Levels of deprivation are high in Barnsley, with the Borough ranked as the 39th most deprived Borough of 326 English Boroughs (where 1 is the most deprived); a decline from 2010 when it was the 47th most deprived area.

  21.8% of areas in Barnsley are amongst the 10% most deprived in England.

  The largest change from 2010 to 2015 for Barnsley is in the Health Deprivation and Disability Domain (HD&DD); within HD&DD Barnsley is ranked 20 out of 326 (where 1 is the most deprived).

  The proportion of children living in poverty is higher in Barnsley than nationally, with 23.8% of under 16s in Barnsley living in poverty compared to 19.2% nationally.

- **Education**

  Educational attainment in Barnsley has continued to improve but remains below the national average at all stages of education. However, between the ages of 7 and 11 pupils in Barnsley make the same or more progress than pupils nationally.

  The percentage of children achieving 5 GCSEs A - C including English and Maths, is significantly lower (47.1% compared to 56.8%);

  Pupil absence rates are significantly higher (5.2 compared to 4.5% half days missed).

  Number of 16 – 18 years old not in education, employment or training, is significantly higher (5.4% compared to 4.7%).

  The recent Joseph Rowntree Foundation report on the causes of poverty adds digital skills to the traditional basic skills of literacy and numeracy (Joseph Rowntree Foundation 2016). Recent data from OFCOM and GO ON UK suggests that (Ofcom 2015, GoON UK 2015):-

  - 27% of Barnsley residents lack basic digital skills
  - 30% of households do not have a fixed broadband connection, and
  - 18% of adult residents have never been online

- **Crime**

  The rate of first contact with youth justice system is nearly 50% higher than the national average (597/100,000 compared to 409);

  Rate of domestic abuse incidents recorded by the police per 1,000 population is higher than national average (30.4 compared to 19.4);

  Admission rates due to injury from violent crime is significantly higher (74 compared to 52 per 100,000).

- **Housing**

  For the Barnsley population in general there are lower rates of statutory homelessness than nationally (0.1/1000 households compared to 2.3).

- **Unemployment**

  Long term unemployment rates in those aged 16 – 64s is significantly higher than national rates (11.1 compared to 7.1/1000).

- **Risk Taking Behaviour**

  In general the Barnsley population continues to have higher than national average levels of smoking, alcohol intake and low levels of physical activity and poorer health food choices.

  The proportion of young people who are regular drinkers at 11.3% (2014 What About Youth Survey) is almost twice the England average of 6.2%.

  Hospital admission rates for adult women from alcohol related conditions are significantly higher than the national average
  (DSR 580 compared to 475/100,000)

  Nearly a quarter of young people undertake three or more risky behaviours (smoking, drinking alcohol, drug use, inactivity, poor diet). This is significantly higher than the England average of 15.9%. Girls (26.7%) are more likely to undertake 3 or more risky behaviours than boys (18.4%)

  The rate of hospital admissions for under 18s from alcohol related conditions has been falling and is similar to the national rate. (Chart One).

  Teenage pregnancy rates, however, are high (Chart Two).

Chart One

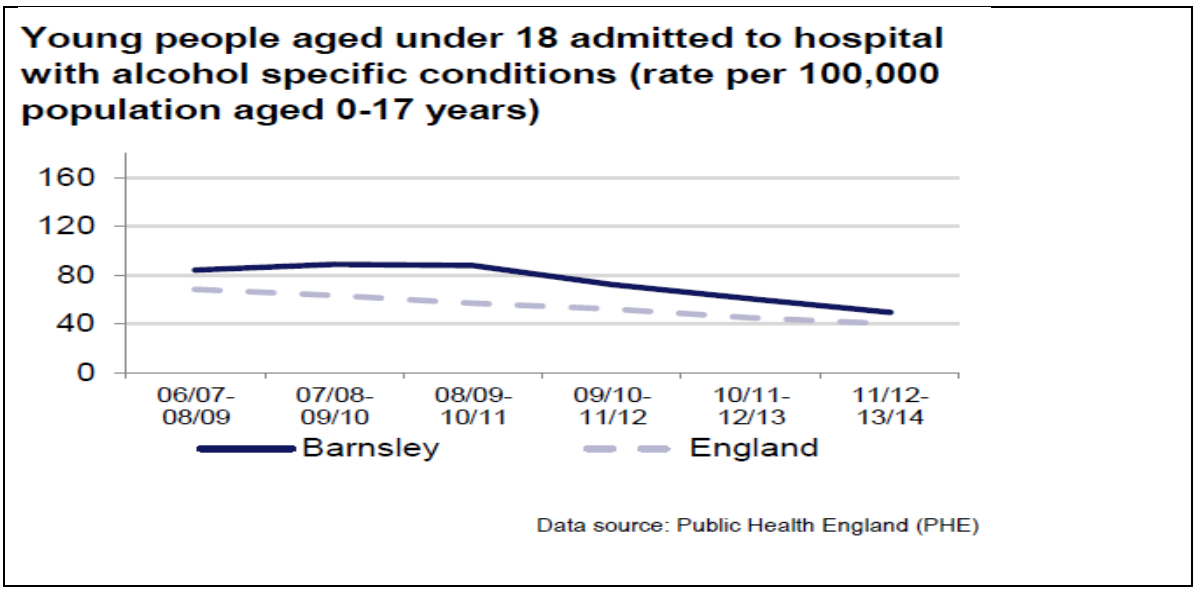
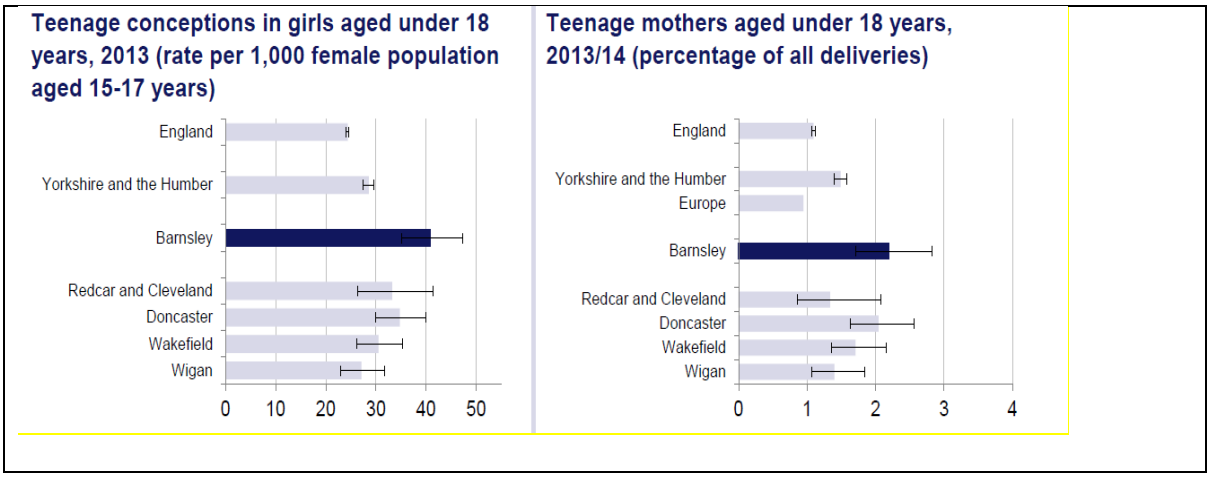


Chart Two



Mental Health of Children and Young People

Nationally

The Future in Mind report highlighted that:-

- Over half of all mental illness starts before the age of 14 & 75% by age of 18;
- The prevalence of mental health disorders in children and adolescence in the last Office for National Statistics survey in 2004, estimated that 9.6% of young people between ages of 5 and 16 years have a mental health disorder (7.7% for those aged 5 – 10 and 11.5% for of 11 – 16's);
- 5.8% of children and young people have a conduct disorder;
- 3.3% an anxiety disorder;
- 0.9% are seriously depressed;
- 1.5% have severe ADHD;
- Bullying is reported by 34 – 46% of school age children. There is a strong relationship between mental and physical health.

Future in Mind notes:-

- 12% of children have a long term condition;
- The presence of a long term condition increases the risk of mental disorder 2 – 6 fold;
- 12.5% of children have medically unexplained symptoms, one third of whom have anxiety or depression;
- People with severe mental health problems such as schizophrenia or bipolar disease die on average 16 – 25 years earlier than the general population.

In Barnsley

The PHE child health profile shows that children and young people in Barnsley are slightly less likely than the national average to be admitted to hospital because of a mental health condition but this is not significantly lower (62.7 per 100,000 age 0 - 17 compared to 87.2%). However, in Barnsley hospital admissions due to:-

- Self-harm – are significantly greater in those aged 10 – 24 (DSR 508 / 100,000 compared to 412);
- Substance misuse - are significantly greater in those aged 15 – 24 (DSR 124/100,000 compared to 81).
- The last Public Health 'Year 10 Survey' for Barnsley was carried out in 2013 and included a section on emotional health and wellbeing. Notable findings of the survey are:-

    - Nearly 10% of respondents felt anxious due to bullying either 'often or daily'
    - Over 20% felt anxious about how they look either 'often or daily';
    - Nearly 10% had been worried about eating problems either 'often or daily';
    - Nearly 12% said they 'never' felt happy at school;
    - Over 12% said that they didn't have anybody to talk to about their Problems. In 2014/15 a company called 'Social Sense' were commissioned to carry out their survey, with schools in Barnsley, which is called 'R U Different', they surveyed year 9 pupils in 6 schools (4 mainstream and 2 special schools). Some of the relevant findings are:-

        - 16% of respondents said they 'often' felt bullied at school;
        - 24% said they felt anxious or depressed 'most days';
        - 29% said that they had harmed themselves as a result of feeling depressed or anxious.

- Barnsley College's Annual Student Survey highlights a year on year;
- Barnsley College's Annual Student Survey highlights a year on year increase in reported loneliness and self-harm.

4. CURRENT SERVICE

The Child and Adolescent Mental Health Services (as a broad term reference) in Barnsley are commissioned through the Children and Young People's Trust. The NHS CAMHS provision is delivered by South West Yorkshire Partnership Foundation Trust (SWYPFT). This multi-disciplinary team provides an evidence-based, comprehensive service to children and young people aged up to 18 years who have a range of clinical needs.

It predominantly provides what were previously known as Tier 3 level services which are out-patient based specialist mental health services. The service is part of the Children and Young People Improving Access to Psychological Therapies (IAPT) Programme that works in partnership with children and young people to help improve and monitor services.

SWYPFT Barnsley CAMHS has reflected the current national trends in terms of rising demand and insufficient capacity as highlighted in the Future in Mind report. As such the service has not had the capacity for robust provision in lower levels of support (previously referred to as Tier 1 and 2 services), consequently it has been hard to influence a reduction in demand successfully, some of which does not require higher levels of support (though will if not effectively addressed). Implementation of the Transformation Plan is beginning to address this imbalance.

Waiting times for both the initial choice appointment and the wait to see an appropriate clinician following choice appointment were unacceptably long. Efforts over the past 12 months have been focused on reducing the wait to the choice appointment, which was 18 weeks, downwards to just 3 weeks. This has been accomplished and a maximum 3 week wait to the choice appointment is being sustained. Efforts are now being refocused on reducing the much longer wait to the start of treatment (Appendix 1: CAMHS Performance data)

It is evident from both the national context and the local referral data that demand for CAMHS has increased significantly over the last 5 years. In order to reduce demand for CAMHS locally the service continue to:-

- Provide and facilitate regular mental health training sessions which are offered to the children's workforce via a safeguarding training brochure, which includes Awareness Level Training and Attachment and Awareness of Mental Health Disorders Training;

- Offer consultation and advice to referrers via a Single Point of Access (SPA) when a referral is made but it is not clear if the child needs specialist services or not. Through the LTP operation of the SPA has been enhanced through investment of additional resource;

- Hold consultation meetings with professional networks for Children in Care, exploring the mental health needs of Looked After Children and who is best placed to provide support / therapeutic input. With additional resources allocated via the LTP, Looked After Children are prioritised when accessing CAMHS services;

- The local CAMHS service does not have the capacity to meet the current, ever increasing demands placed upon it, in part due to there being a lack of lower level support offered within Barnsley. The core of the transformation plan therefore continues to focus on developing robust, lower level support for children and young people's emotional health and wellbeing to assist in reducing the referrals in to specialist services;

- Early intervention and prevention, as a whole system approach, is the focus of the Future in Mind investment in Barnsley (Appendix 2: FiM Funding Allocation). Prevention and intervention in emotional wellbeing and mental health targeted at children and young people will result in greater benefits and savings than interventions at any other time in their life span (DH 2011)[1]. It is the intention that the investment will enable the delivery of evidence based outcome specific services.

[1] Children and Young Peoples Emotional Wellbeing and Mental Health National Support Team – The Learning: 'What good looks like, (April 2011, DOH)

5. TRANSFORMATION WORK

The vision for Barnsley is for early intervention and prevention models to provide innovative wellbeing and prevention focused service(s) that can meet the needs of the children and young people already known to services and professionals across the borough, in addition to identifying others with needs that are currently not being met or supported by other services and extending the ability to recognise and offer support to all those with emotional wellbeing needs.

The work is delivered on an asset model and will focus on promoting factors that support human health and wellbeing (salutogenic) resources that build the self-esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services.

The services are operating within the context of wider systems to maximise synergy, reduce duplication and ensure impact across the existing systems and future developments, enabling the adults who form the child and young person's environment (teachers, professionals, parents, carers etc.) to role model high self-esteem and personal resilience, which in turn will allow children and young people in Barnsley to 'break the cycle' of low aspirations and improve mental and physical health associated with wellbeing.

The expected outcomes of the early intervention and prevention model include:-

- Improved quality of life outcomes for children and young people by supporting them to build resilience, understand how to maintain their wellbeing and enabling self-care;

- Improved confidence and competence of children and young people facing staff to identify, comfortably and compassionately engage with and signpost children and young people into services via a clear pathway;

- Improved entry assessment and final evaluation outcomes of CAMHS by providing step up/step down services;

- Reduced number of referrals into secondary care/higher level services (for mental health/wellbeing);

- Reduced number of refused referrals submitted to CAMHS;

- Reduced emergency admissions to hospital for Children and Young People with Long Term Conditions – children and their parents are less anxious and have access to information that allows them to effectively self-care;

- Reduced incidence of bullying in schools;

- Reduced incidence of child sexual exploitation;

- Reduced number of children and young people prescribed anti-depressants;

- Increased early identification at key development ages within existing services;

- Improved information, advice and support available for children and young people, and their families and carers, enabling them to effectively self-care and support the emotional wellbeing of themselves and those around them.

In recognition of resource constraints the Future in Mind Stakeholder Engagement Group agreed to focus the additional investment primarily on the implementation of a Resilience model, as developed by Public Health colleagues and partners and the further development of a Therapeutic team proposed by Springwell Academy in collaboration with the local CAMHS service and fully supported by primary and secondary schools within the Borough. The Therapeutic Mental Health Team will also provide support to those children and young people waiting for their first CAMHS appointment.

4:Thought (Previously known as 'BETTER PLUSSS')

This school-led mental health therapeutic team is now known as '4:Thought', following a competition among Barnsley's children and young people to name the team. The winner of the competition (a client of CAMHS) is currently working with the team to design its branding.

'4:Thought' has been developed in partnership with NHS CAMHS, Chilypep, Barnsley TADS (Therapies for Anxiety, Depression and Stress) and SYEDA (South Yorkshire Eating Disorder Association).

'4:Thought' consists of:-

- 3 mental health practitioners;
- 1 parent counsellor;
- 1 family practitioner;
- 1 teacher;
- Educational Psychologist input from the local team.

'4:Thought' is based at Springwell Alternative Academy in Kendray with each of the 10 **Secondary Schools** in Barnsley being allocated to one of the teams' three mental health practitioners. A website has been developed to enable any one to access information about the service, its governance arrangements and information about referrals (http://springwelllearningcommunity.co.uk/contact-4-thought/).

Aligned to the development of '4:Thought' partners are providing training to all staff at each of the 10 Barnsley Secondary schools. The training provided to staff includes:-

- Youth Mental Health First Aid;
- Mental health awareness, self-harm and suicide;
- Anxiety and depression;
- Alcohol and substance misuse;
- Eating disorders;
- Building the confidence and self-esteem of young people;
- Exploring the issues affecting young people and signposting;
- Self-help strategies to support young people's wellbeing.

It is expected that this service will provide:-

- Emotional Well Being (EWB) focused peer support;
- Peer led EWB events;
- EWB training and support for peers;
- Engagement campaign to de-stigmatise mental health/promote emotional wellbeing with positive messages;
- Therapeutic group work and EWB sessions including creative, active, discursive and artistic;
- Improved access to early intervention therapeutic support through outcome focused 1-1 work, where appropriate/clinically indicated;
- Practical interventions, supporting children and young people to develop their own safety plans if/where appropriate;
- Attendance at school, college and community events where appropriate, promoting the service and self-care/prevention messages;
- A comprehensive training programme;
- An interactive website.

As evidenced by models of delivery similar to ‘’4:Thought’ elsewhere in England, it is anticipated that upwards of 200 children and young people per annum will have their needs met by this service on a 1:1 basis and a further 75 children and young people within group sessions. Appropriate outcome metrics are currently being developed to evidence the effectiveness of 4:Thought.

Engagement With Children & Young People

Children and Young People’s Empowerment Project (Chilypep) are undertaking work alongside children and young people aged 8 – 25, to find fun and creative ways of involving them in decisions that affect their lives. As part of the transformational work in Barnsley, Chilypep have been commissioned to develop and provide training for ‘young commissioners’ in order that the ‘young commissioners’ can directly influence the commissioning of children’s services in Barnsley (Appendix 4: Recruitment Poster)

In addition, Chilypep have also re-launched their ‘Peer Mentoring’ programme at Barnsley College (Appendix 3: Pilot Evaluation Report). This early intervention and prevention programme was initially piloted in Barnsley college from 1 November 2014 – 31 July 2015. The video link below shows the positive impact of the work undertaken and highlights the benefits of the programme to the current and future students. https://www.youtube.com/watch?v=BWg1VMcq364

Overall, Chilypep have consulted and engaged over 113 children and young people to date as part of the transformation work.

TADS (Therapies for Anxiety, Depression and Stress)

Barnsley TADS is a Charitable Unincorporated Organisation who provide free complimentary therapies to the people of Barnsley. Barnsley TADS did not form part of the original transformation plan but through the extensive engagement, development and promotion of ‘4:Thought’, they have become and enthusiastic and committed collaborative partner.

Barnsley TADS have established a 'TADS Young People's Wellbeing project' which includes:

- Running a drop in service twice a week between 3:30pm and 5:30pm;
- Offering a five-week wellbeing workshop teaching young people different ways to handle their issues;
- Provide therapies such as Indian head massage, reflexology, reiki, hypnotherapy and EFT (Emotional Freedom Techniques);
- A dedicated, confidential email and text messaging service for advice and/ or support;
- Barnsley TADS are also one of the partners involved in the development of '4: Thought' and they provide some elements of this service.

THRIVE (Previously known as 'BETTER')

The focus of this project is early intervention and prevention to promote resilience in young people. The project is led by Barnsley's Public Health Team and is aimed at Barnsley's **Primary School Children.**

The aim of the project is to improve the social and emotional mental health (SEMH) and resilience of young people in Barnsley through increasing the number of Primary schools providing exemplary mental health support for their pupils delivered through a whole school approach.

The overwhelming evidence is that as well as a whole school approach, interventions need substantial dedicated time to produce benefits. This project aims to support schools to be able to achieve this, initially through enabling them to implement the 'Thrive approach' as part of a whole school approach to SEMH.

Due to the limited resources available it was necessary to identify priority schools. The priority schools were identified by several factors, including the area of deprivation, numbers of exclusions, numbers of unauthorised absences and numbers of CAMHS and Educational Psychology referrals.

Phase 1 of the project commenced in October 2016 with 3 staff from 8 priority schools undertaking the Licensed Practitioner Course. Phase 2 will see a further 24 staff undertaking the Licensed Practitioner Course in March 2017 as well as 5 members of school staff undertaking Train the Trainer courses. Phase 3 is aimed at schools in Barnsley who have already adopted the Thrive approach and a further 24 staff members of these schools will undertake the Licensed Practitioner course.

The expected outcomes to be delivered include:-

- Improved levels of SEMH as measured by the Strengths and Difficulties questionnaire (SDQ) – the SDQ is a well validated brief screening questionnaire for 4 – 17 year olds;
- Reduced requirement for additional higher level mental health support (longer term reduction in CAMHS referrals);
- Improved levels of happiness and feeling safe (pre and post intervention pictorial questionnaire);
- Improved behaviours in home and school (SDQ / teacher and parental questionnaires) - including reductions in low level disruption and bullying;

- Longer term improved academic attainment (school academic data);
- Longer term improved school attendance (school data).
- Longer term reduced instances of exclusions;
- Longer term reduced instances of unauthorised absences (school data);
- Improved development of the social and emotional skills and attitudes that promote learning and success in school and throughout life;
- Improved staff wellbeing and happiness - reduced stress, sickness and absence;
- Improved levels of resilience may mean that young people are more able to cope with, for example, low-level anxiety, frustration and anger, recovering from setbacks and being persistent in the face of difficulties;
- Reduction in risky behaviours.

This work with schools is supported by Public Health who will ensure that this work complements that of the 0 – 19 health and wellbeing service (Health Visiting School Nursing). The steering group for this project is the Barnsley Schools Alliance 'Closing the Gap' group which includes schools representatives. The Project Manager is a member of the Public Health team in Barnsley and a member of the Future in Mind Stakeholder Engagement Group.

NHS CAMHS

CAMHS services have generally been delivered in line with the four-tiered national framework with Tiers 1 and Tier 2 providing lower levels of emotional health and wellbeing support, often provided by mental health specialists in universal services such as GP's, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. NHS CAMHS is a specialist CAMHS service provided at Tier 3, a much higher level of emotional health and wellbeing support to children and young people. Tier 4 relates to in-patient treatment and is commissioned by NHS England.

There is often a misunderstanding that a child or young person will move up through the Tiers as their condition is more complex but the needs of children and young people do not fit neatly into the Tiers and in reality, some children require services from a number of (or even all) Tiers at the same time. In Barnsley we are therefore moving away from the idea of tiered support and focusing on developing services tailored to meet the emotional health and wellbeing needs of children and young people within the Borough.

The Barnsley Child and Adolescent Mental Health Service (CAMHS) is based at Upper New Street, Barnsley and provides a comprehensive and quality service to children and young people in the Barnsley area. The services are provided to children and young people up to their 18th birthday who are experiencing a wide range of behavioural, psychological and emotional problems, difficult relationships, trauma or abuse. 100% of young people presenting to Barnsley CAMHS in an emergency are seen within 24 hours.

Barnsley CAMHS is part of the children and young people improving access to psychological therapies (IAPT) programme that works in partnership with children and young people to help improve and monitor services.

Barnsley CAMHS is made up of four teams:-

- Child and Adolescent Unit;
- Young People's Outreach Team;
- Community Early Intervention Team;
- Learning Disabilities and Development Disorders Team.

The services are provided in a variety of settings including health centres, clinics, schools or in service user homes. There is a range of support and interventions offered to children, young people, families and carers who use the Barnsley CAMHS service. Examples of this support includes:-

- Brief solution focused therapy (a goal directed therapy that focuses on solutions instead of problems);
- Cognitive behavioural therapy (CBT) (a talking therapy that can help you manage your problems by changing the way you think or behave);
- Evidence based parenting interventions;
- Eye movement desensitisation reprogramming (a treatment used to reduce the symptoms of post-traumatic stress disorder);
- Family therapy;
- Group therapies;
- Play therapy;
- Psychiatric assessment and diagnosis;
- Psychologist assessment and interventions.

The specialist team includes psychiatrists, specialist nurses, psychologists, specialist social workers and therapists who help children, young people and their families, on both an individual and group basis. Barnsley CAMHS also offer their mental health expertise across children's services in the area, providing consultation, training and advice to carers, families and other professionals.

Long waiting times to the commencement of treatment in Barnsley CAMHS continues to be an issue. Significant progress has been made in reducing the initial wait for an appointment from 18 weeks to 3 weeks but children and young people may then wait almost a year before their treatment begins. This is unacceptable and commissioners and service providers are working closely together to significantly reduce the waiting times.

Actions to date include additional investment to enhance the operation of the CAMHS Single Point of Access and to enhance CAMHS support to the Youth Offending Team and for priority access to CAMHS for Looked After Children. Re-design of the ASD / ADHD pathway has been undertaken and the pathway is working well although the funding for this service needs to be re-modelled to further consider CAMHS capacity. The Future in Mind investment is being utilized to develop lower level emotional and wellbeing support to children and young people in Barnsley to prevent escalation to crisis point and additional non-recurrent monies from NHS England will be used to increase the capacity of CAMHS to offer greater access to CBT.

Barnsley CAMHS have been an important partner in the development of '4:Thought', working closely with the schools lead, Springwell Academy, and will continue to work in partnership with schools to ensure '4:Thought' provides a robust, evidence-based service to the children and young people of Barnsley.

Barnsley CAMHS had previously initiated the development of a **Single Point of Access (SPA)** but its operation was limited. As part of the transformation work funding was allocated to the NHS CAMHS service to enhance and further develop the SPA, utilising learning from Barnsley's own brokerage service, Rightcare Barnsley, to ensure children and young people receive the right treatment, in the right place at the right time. Further work is required to fully operationalise this in 17/8.

Exposure to crime and anti-social behaviour are one of the determinants of poor emotional health and wellbeing in children and young people. In recognition of this Future in Mind funding has been utilised to increase CAMHS capacity to provide additional input into the **Youth Offending Team**. This is enabling timely access to the support needed by this vulnerable group of children and young people.

Community Eating Disorder Service

A community eating disorder service provided by CAMHS has been established in Barnsley in accordance with the recommendations of the guidance for 'Access and Waiting Time Standard for Children and Young People with Eating Disorder'. The Barnsley service has been established through a collaborative commissioning arrangement with four other CCG's, these being Wakefield, Kirklees, Greater Huddersfield and Calderdale.

Through the consultation for Future in Mind we identified the need for more CBT and Family Therapy which has been reflected in the regional model. The number of Barnsley children and young people anticipated to be able to be seen through the eating disorder pathway will be triple the numbers that had previously been seen.

The regional group are focusing on producing an outcome based model, and are working collaboratively with our provider to explore the current provision and how to effectively implement the service. Barnsley, Wakefield, Kirklees, Calderdale and Greater Huddersfield have redesigned service provision to ensure we are compliant with the waiting time standards set out in the guidance. (See Appendix 5 for full implementation plan).

Children and Young Peoples Improving Access to Psychological Therapies (CYP IAPT)

Barnsley CAMHS has participated in the national programme since the first implementation phase in 2012. The service is part of the North West CYP IAPT Learning Collaborative. There are currently 20 partnership members of the collaborative - supported by Greater Manchester West Cognitive Behavioural Therapy Training Centre (GMW CBTTC)/The University of Manchester.

CYP IAPT is a pivotal factor in delivering the Five Year Forward View in Mental Health objective of enabling an additional 70,000 additional children and young people in England to access emotional health and wellbeing support by 2020.

A key component of CYP IAPT is the training of practitioners (and supervisors) in NICE approved and best evidence based therapies. Historically, NHS England has funded the backfill posts to enable staff to undertake this training, but the level of future funding is reducing.

It is vital that this training continues and that it is incorporated into the workforce plan. In recognition of this, an element of the Future in Mind resource will be allocated recurrently for this purpose.

Accessible Information

In both previous and current consultations with children and young people in Barnsley it is evident that there is a general lack of awareness among children and young people as to the emotional health and wellbeing support that is available to them, locally and nationally and that even when the children and young people are aware of services, they are not always aware of how to access them.

To remedy this an element of the Future in Mind funding has been utilised to look at the development of a 'one-stop-shop' model of accessible service information. Links have been made to the work being undertaken by Chilypep and to the Local Authority's own 'I Know I Can' website, as well as to the Family Centres Information Advisory Service, the CAMHS SPA and '4:Thought'.. Learning is being shared and all partners are working towards delivering a robust, real-time information service to all children and young people in Barnsley.

Perinatal Mental Health

Barnsley's Perinatal Mental Health pathway has been reviewed (Appendix 6) and reflects the engagement with in-patient and outreach services to prevent relapse. There are close links with Barnsley's IAPT (Improving Access to Psychological Therapies) service who are supporting up to 300 women per year. However, a gap still exists with regards to pre-conception support and this is an area that will be targeted locally with the impending future national resource.

A key priority however, and the key to substantially enhancing the perinatal support in Barnsley, is the development of a Specialist Perinatal Mental Health Team. The numbers of births in Barnsley (approximately 3,000 per year) are not high enough to warrant developing such a specialist team locally but it could be effective on a sub-regional basis.

With this in mind, Barnsley have recently supported a collaborative bid, with Kirklees, Calderdale and Wakefield CCG's, to NHS England's' Service Development Fund to establish a sub-regional Specialist Mental Health Service.

A Maternal Mental Health strategy group, led by Barnsley Hospital NHS Foundation Trust leads on developing a perinatal mental health strategy, perinatal mental health being a key priority outlined in Barnsley's All-age Mental Health and Wellbeing Commissioning Strategy.

Looked After Children

Outcomes for Looked After Children often fall behind that of other children and young people simply due to their life experiences which lead them to becoming looked after by the Local Authority. This inequity has been recognised and in response Future in Mind resource is being utilised to ensure that Looked After Children have priority access to CAMHS to ensure that they receive the most appropriate treatment in a timely manner to prevent escalation to crisis.

Child Sexual Exploitation

Child Sexual Exploitation (CSE) is a reality in all towns and cities in the UK and Barnsley is no exception. Health and social care organisations in Barnsley are working very closely together with partners (including South Yorkshire Police and SWYPFT and voluntary sector organisations (namely BSARCS – Barnsley Sexual Abuse and Rape Crisis Services)) to ensure that the children involved in such exploitation receive the specialist treatment necessary to enable them to reach full recovery. The local authority and CCG have recently jointly commissioned an enhancement to the BSARC service to ensure children receive timely therapeutic support post episodes of sexual violence. The Transformation Plan needs to ensure this function is resourced recurrently

Work is also undertaken to raise the awareness of CSE within the community to reduce opportunities for such exploitation to occur and to work with perpetrators to prevent future exploitation in this way. CSE awareness is built into resilience work.

Mental Health Crisis Care

Barnsley CCG and its partners continue to work closely together to implement the Barnsley Mental Health Crisis Care Concordat Action Plan to improve the crisis care of anyone in Barnsley who requires such help, where and when they need it.

Barnsley's Mental Health Crisis Care Concordat Group are currently refreshing the Concordat Action Plan and improving the crisis care for under 18's is a key focus. Regionally, within South Yorkshire, there are plans to develop a health-based place of safety suitable for young people to be taken whose mental health crisis warrants the police to use S136. Very few young people in Barnsley have been placed on a S136 order (one in the last 3 years) but when the need arises a health based place of safety is needed for them that is a safehaven but is not frightening (police custody cells were used prior to November 2015).

If children and young people present at Barnsley Hospital A&E in mental health crisis they are currently seen by Barnsley CAMHS. The Psychiatric Liaison service based at the hospital only covers adults (18 year olds and over) but plans are being considered to develop an appropriate NICE recommended psychiatric liaison model that will incorporate 16 and 17 year olds. Commissioners and providers are working together to develop appropriate metrics based on the Liaison Psychiatry Frequently Reported Outcome Measures (Appendix 7).

0 – 19 Health and Wellbeing Service

The aim of the Healthy Child Programme delivered through a 0 – 19 Health and Wellbeing service is to protect and promote the health and wellbeing of children, young people and their families. The service will work in partnership with other agencies and offer a needs-led offer in line with the key health and wellbeing outcomes including supporting children, young people and families to be empowered to make positive choices in leading happy, healthy lives.

From October 2016 Barnsley Metropolitan Borough Council became responsible for delivering the 0 – 19 health and wellbeing service. Although the transition of the service to the Local Authority may cause some initial teething problems it will undoubtedly provide valuable opportunities for collaborative, effective working among partners.

6. COLLABORATIVE WORKING WITH NHS ENGLAND

Mental Health Specialised Commissioning Team

NHS England has commenced a national Mental Health Service Review and now has an established national Mental Health Programme Board to lead on this process. The Mental Health Service Review will be locally directed and driven so that the services meet the needs of local populations. Yorkshire and Humber commenced procurement of general adolescent and psychiatric intensive care inpatient services ahead of the national timescales. The way that the procurement is organised will mean that the Yorkshire and Humber area will be divided into three geographical Lots; the first Lot to be procured will be services for Hull, East Riding of Yorkshire, North and North East Lincolnshire.

The remaining two Lots are Lot 2; West Yorkshire, North Yorkshire and York, and Lot 3; South Yorkshire. Timescales for these areas are yet to be announced.

A detailed piece of work has been carried out to assess the numbers of beds required and in which geographical locations (Appendix 8 – Tier 4 Bed usage). Lot 1 bed requirements are 11 in total which incorporates General Adolescent beds with psychiatric intensive care beds. This service will provide for the populations of Hull Clinical Commissioning Group, East Riding of Yorkshire Clinical Commissioning Group, North Lincolnshire Clinical Commissioning Group and North East Lincolnshire Clinical Commissioning Group.

NHS England is leading a new programme, announced in the Planning Guidance 16/17, that aims to put local clinicians and managers in charge of both managing tertiary budgets and providing high quality secondary care services. Tees, Esk and Wear Valley Foundation Trust was selected as one of the providers selected as the first-wave sites, working towards a go-live date in October 2016 to cover the North East and North Yorkshire. This will provide the incentive and responsibility to put in place new approaches which will strengthen care pathways to:-

- improve access to community support;
- prevent avoidable admissions;
- reduce the length of in-patient stays and;
- eliminate clinically inappropriate out of area placements.

It is clear from the CAMHS benchmarking that has taken place that there is significant variation in usage of Tier 4 beds as well as the length of stay in these units. The data shows that there is a link between this 21tilization and lack of Intensive Community CAMHS services available in a CCG area; it is envisaged that the development of the LTP is a significant opportunity to develop Intensive Home Treatment and Crisis Services to reduce the need for admission. In order to improve the quality and outcomes for children and young people we will work closely with identified lead commissioners in Y&H to ensure that CAMHS Service Review and local plans link with Sustainable Transformation Plan (STP) footprints. This will enable better understanding of the variation that currently exists across YH to help identify opportunities to challenge this in order to ensure equity of access, outcomes and experience for all patients.

The aim is to develop greater understanding of patient flows and the functional relationship between services to work with commissioners and providers to support new and innovative ways of commissioning and providing services, in order to improve quality and cost effectiveness. This work will continue to carry out collaboratively through the Children and Maternity Strategic Clinical Network which includes all relevant stakeholders.

Health and Justice

High numbers of children who offend have health, education and social care needs, which, if not met at an early age, can lead to a lifetime of declining health and worsening offending behaviour, with significant long-term costs to the taxpayer and to the victims of these crimes. In recent years national policy on sentencing for children who offend has changed, with around 97% now subject to community supervision as opposed to custodial sentencing.

All children who come into contact with youth justice services are vulnerable by virtue of their young age and developmental immaturity. Many however, are doubly vulnerable – that is, they are disadvantaged socially, educationally and also because they experience a range of impairments and emotional difficulties. It is well established that children who offend have more complex health and support needs than other children of their age.

Evidence suggests that between a third and a half of children in custody have diagnosable mental health disorders and 43% of children on community orders have emotional and mental health needs. Research studies consistently show high numbers of children in the youth justice system have a learning disability, while more than three-quarters have serious difficulties with literacy and over half of the children and young people who offend have themselves been victims of crime.

Children who are, or who have been, in care are over-represented among the offender population. Research shows that 42% of children on custodial sentences had been ‘held in care’, while 17% were on the child protection register.

The case for priority access to CAMHS is particularly strong for those identified with early behaviour problems and ADHD (both of which are known to have strong associations with offending behaviour, substance misuse and later mental health problems), those who have suffered previous maltreatment, young females (who have high levels of mental health and other needs), young people from BME communities (who remain over-represented in custody settings), and those with mild to moderate learning disabilities and communications difficulties, who currently fail to access community services.
Children who offend don’t always get early help with health needs – yet early intervention will lead to better outcomes. NICE guidance (2013) supports clearer evidence of what works to support children’s and community outcomes – working with families and systems around the young person.

Commissioners across the whole system need to work together to ensure integrated care pathways to enable young offenders with mental health problems at all stages of the criminal justice pathway can get the most appropriate care at the right time by the right person.

The success of the YOT model has been widely acknowledged as an effective way of providing children who offend with the right mix of care, supervision and rehabilitation. The importance of integrated service provision within the Youth Offending Service (YOS) with clear care pathways is vital in the youth justice system where mental health problems in children who offend may be identified for the first time, but with a limited window of opportunity to assess need, plan for and deliver an appropriate intervention. Challenges include:-

- Threshold for acceptance into CAMHS is high and can exclude children with lower level, multiple and often complex mental health needs. Children under the supervision of youth justice services and those identified as being at risk of offending must not be marginalised and they should have equal access to comprehensive CAMH services;

- Specialist YOT CAMHS workers, or clear pathways into CAMHS, are needed to support children with a community sentence and should be available for those on release from secure accommodation.

Effective parenting work is also undertaken by both the Youth Offending Team Service and the Multi-Systemic Therapy service. Complementing these services is the parenting work undertaken through CAMHS, voluntary partners and Early Years services. Enhancing parenting initiatives within the Borough will result in wide ranging benefits for the child, the family and the community as a whole and will be a focus of the 2016/17 funding allocation.

Children referred to Forensic CAMHS (FCAMHs) may be involved with the youth justice system or be at high risk of being so in the future. They are likely to present with behavioural problems like violence and aggression towards others, harming themselves, fire setting or engaging in sexually inappropriate behaviour. FCAMH services work collaboratively with other agencies working in the youth justice system, there should be a dual emphasis on promoting and enabling individual recovery and independence, while also ensuring the protection of the public.

Challenges in service delivery include:-

- The time of highest risk for children is during the transition between different parts of the pathway – it is essential this transition is managed safely and effectively. This is particularly the case for the transition from secure accommodation to increased independence and responsibility in the community. There is a need for children on release from the secure estate to be referred to a community forensic CAMHs if they have been assessed within the estate as needing a service, but the sentence has been too short to start or complete an intervention;

- The principle of ‘equivalence of care’ established that people (including children) in prison should have the same standard of care that is available to the wider (non-imprisoned) population. The 3 secure establishments for children in Yorkshire and Humber, namely HMYOI Wetherby, Aldine House and Adel Beck Secure Children’s Homes all have access to FCAMHS but there is often no community service to provide treatment or follow-up available.

Liaison and Diversion (L&D) services operate by referring offenders who are identified with having mental health, learning disabilities, substance misuse or other vulnerabilities to an appropriate treatment or support service. At the point of arrest, there is an opportunity to identify these needs early on, to link to young people and their families with the support they need and to reduce the chance of people going in and out of the youth justice system. Most adults with poor mental health first present with symptoms during their teenage years so early intervention is critical to promote children's life chances and reduce multi-sector costs. An independent evaluation found that young people involved in L&D services took longer to reoffend and showed significant improvements in managing depression and reducing self-harming.

Challenges in service delivery include:-

- Following assessment by the L&D practitioner the child is referred to the most appropriate mainstream, YOS, and voluntary health and social care services to meet their mental health needs. Clear care pathways, linked with schools and other settings/partners as part of referrals, need to be established into comprehensive CAMHS for children that are on the fringes of early criminal activity right up until their resettlement after custody;

- Pathways from L&D services will need to include services for those with mental health and behavioural difficulties as well as care pathways for those comorbid mental health and learning disabilities.

7. GOVERNANCE

Barnsley has had well-developed partnerships and integrated working arrangements for some time which has enabled strong partnerships to be developed to ensure delivery of the objectives of the transformation plan.

The Future in Mind Stakeholder Engagement Group (Appendix 9: TOR) is accountable to both the Children and Young People's Trust (formed in 2007) and the Trust Executive Group (TEG) which was established to ensure a partnership approach to encourage integration in the Children's workforce to prevent the developing of isolated solutions to system-wide issues. Membership of TEG include the following:-

Barnsley Metropolitan Borough Council (BMBC)

- Executive Director for the People Directorate;
- Service Director, Children's Social Care and Safeguarding;
- Service Director, Education, Early Start and Prevention;
- Head of Public Health;
- Interim Head of Barnsley Schools Alliance;
- BMBC Cabinet Members;
- Spokesperson for Achieving Potential;
- Spokesperson for Safeguarding;
- Barnsley Safeguarding Children Board Independent Chairperson;
- Voluntary Action Barnsley;
- Barnsley Hospital NHS Foundation Trust;
- Head of Midwifery;
- Barnsley Association of Head-teachers of Primary, Special and Nursery Schools;
- The Association for Secondary Head-teachers working in Barnsley Local Authority;
- Barnsley Clinical Commissioning Group – Chief Nurse;
- Barnsley College - Vice Principal Teaching, Learning and Student Support;
- South Yorkshire Police – Chief Superintendent;
- South West Yorkshire Partnership Foundation Trust (SWYPFT) - Deputy Director of Operations;
- South Yorkshire Community Rehabilitation Company (CRC), Sheffield/ Barnsley Cluster - Assistant Chief Executive;
- Barnsley Local Medical Committee – GP;
- School Governors;
- Youth Council;
- Job Centre Plus (to be invited as and when required).

BMBC

- Head of Commissioning, Governance and Partnerships;
- Strategic Lead, Procurement and Partnerships;
- Performance Improvement Officer;
- Governance, Partnerships and Projects Officer.

The seniority of the members of the TEG (which reports directly to the Health and Wellbeing Board) reflects the influence that each is able to bring to their organisations. Each member is committed to delivering the transformation plan and this commitment is pivotal in ensuring that the required culture change is effected, this being essential for the transformation plan to succeed.

Reporting to TEG is the Children's Executive Commissioning Group (ECG). Both the TEG and ECG are chaired by Rachel Dickinson, Executive Director for the People Directorate at Barnsley Metropolitan Borough Council, who is also a member of Barnsley's Health and Wellbeing Board.

The Children's Executive Commissioning Group membership includes the following:-

- BMBC Executive Director People (Chair);
- BCCG Chief Nurse;
- BMBC / BCCG Children's Services Commissioners;
- Public Health;
- BMBC Service Director Education, Early Start and Prevention;
- BMBC Service Director Children's Social Care and Safeguarding;
- NHS England.

The Future in Mind Stakeholder Engagement Group is led by the CCG's Chief Nurse and reports directly into the Children's Executive Commissioning Group, in recognition of the fluidity of the group and the access required to key stakeholders to enable partners to drive forward the implementation of the transformation plan.

Barnsley CCG is the nominated lead commissioner for the Future in Mind project and therefore co-ordinates and chairs the Future in Mind Stakeholder Engagement meetings and updates ECG on a monthly basis. These clear and robust governance arrangements are effectively ensuring delivery of the priorities within the transformation plan (Appendix 10: Governance flowchart)

8. NEXT STEPS

We are in the second year of a five year transformation plan to improve the emotional health and wellbeing of children and young people in Barnsley. Barnsley's transformation plan focuses on providing lower level emotional health and wellbeing support to children and young people and to date, has focused on the development of '4:Thought' for secondary school students and implementation of the THRIVE Resilience programme for primary schools. It has been acknowledged however that more could be done to improve links with Barnsley's Early Help Offer, particularly in relation to the services provided by the Family Centres.

The Early Start and Families service aims to ensure high quality delivery of integrated services and strategies which impact on the outcomes and life chances of children, young people and families pre-birth to 25 years including the implementation of key statutory duties.

Family Centres bring together practitioners from a range of universal, targeted and specialist services in each local area including schools, police, social care, private and voluntary sector and some adult services.
Services delivered will vary in each area depending on the needs of families and the wider community.

Early help services are co-ordinated and delivered through Family Centres and:-

- Support children to be ready for school and thrive in school
- Support parents and carers to develop their parenting skills
- Support parents and carers to develop personal skills, access training and education and enhance their ability to access employment
- Support parents and carers to keep children safe
- Help children to achieve their full potential and reduce inequalities in their health and development
- Support the development of healthy lifestyles for children
- Support families to build their own resilience

Partners within the Future in Mind Stakeholder Engagement Group will collaborate closely to ensure that services offered are as effective as possible and accessible by everyone who needs them. For example, both Family Centres and CAMHS offer parenting programmes and these services will work together to develop a more robust, effective service.

It has also been acknowledged that implementing the THRIVE approach may not be appropriate for all primary schools in Barnsley. Alternatives, such as developing school counselling services are therefore being considered.

The level of lower level support needed in relation to eating disorders among children and young people is relatively unknown in Barnsley but evidence is building which suggests that there is a growing unmet need. Consideration is therefore being given to the possibility of developing a school eating disorder counselling service aimed at the children and young people themselves to both provide the support needed and to prevent escalation of the eating disorder to such a level that specialist treatment is required.

9. SUMMARY

It is evident within Barnsley that there is still much that can be done to improve the emotional health and wellbeing of the children and young people resident within the Borough. Bringing all of the agencies together to work collaboratively to deliver evidence based services commissioned against outcome specifications is beginning to achieve positive results.

The investment opportunities being made available are welcomed by all of the parties and key stakeholders involved and we are determined to ensure that a real difference is made to the lives of the children and young people in Barnsley by focusing on those elements that will have greatest impact.

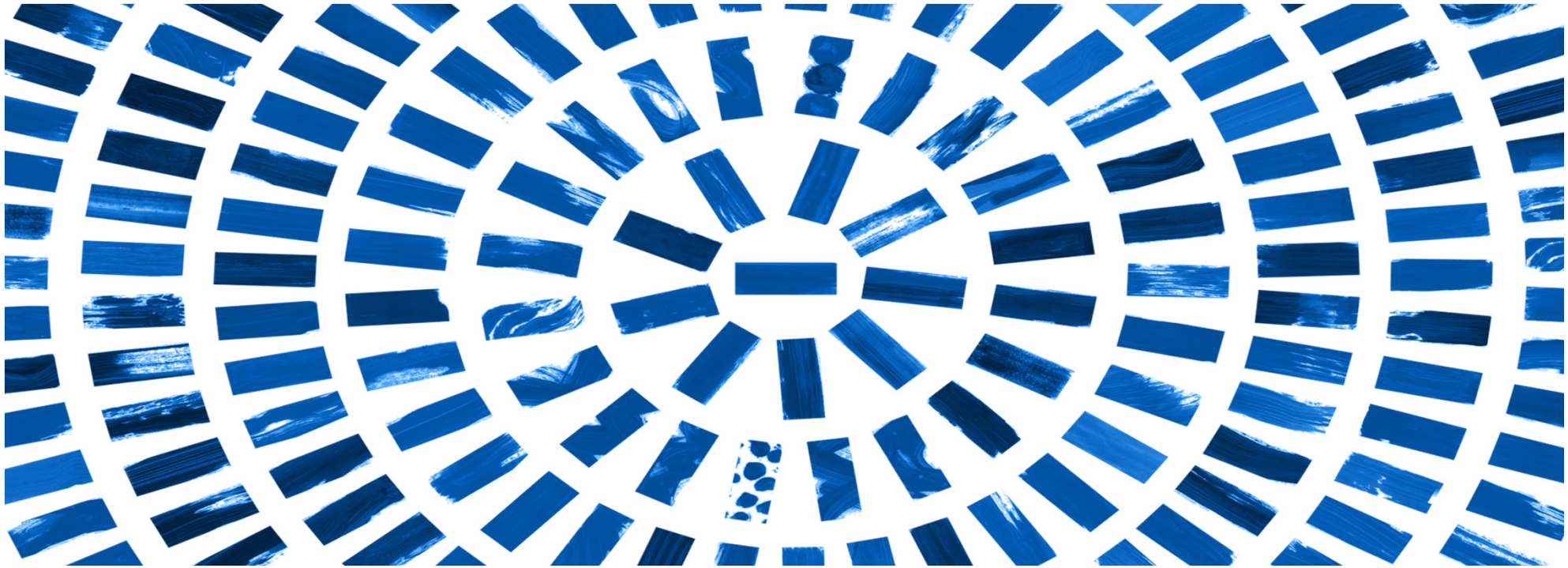
The focus of the investment in Barnsley will continue to be based on early intervention and prevention models, improving the resilience of the children and young people to prevent the need for access to intensive support, such as CAMHS, and providing support to those children and young people on the CAMHS waiting list to prevent further deterioration within the whole setting approach.

The continued investment in 2016/17 will enable the initial developments to be evaluated and where successful rolled-out across the Borough to ensure equity of access for all Barnsley's children and young people.

South West Yorkshire Partnership NHS
NHS Foundation Trust

CAMHS Key Performance Indicators

Barnsley



August 2016

With **all of us** in mind.

Contents

Supporting Information

For the following KPI topics, activity and performance are reported based on the CCG of the client:

- Referrals
- Contacts
- Waits
- Did not attend (DNA)
- Caseload

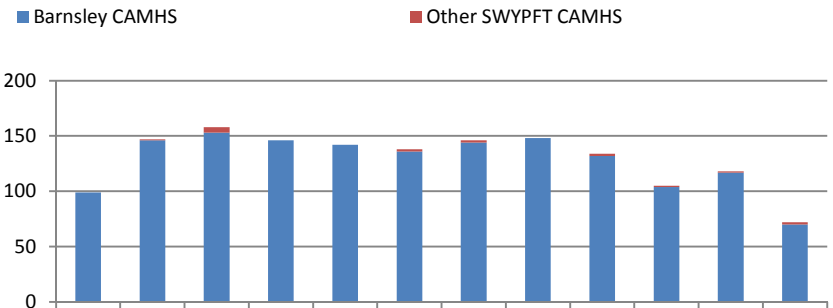
- For example - Total referrals received KPI: contains any Calderdale CCG client no matter which SWYPFT CAMHS service they have accessed.

- The CCG of a client is determined by the GP practice the client is registered with.

- Since the upgrade to the RiO clinical system in November 2015, there has been intermittant problems accessing the system that have hampered real time data capture and created problems with extracting data for reporting purposes across the organisation, particularly during January. Data for November to March should be used with caution.

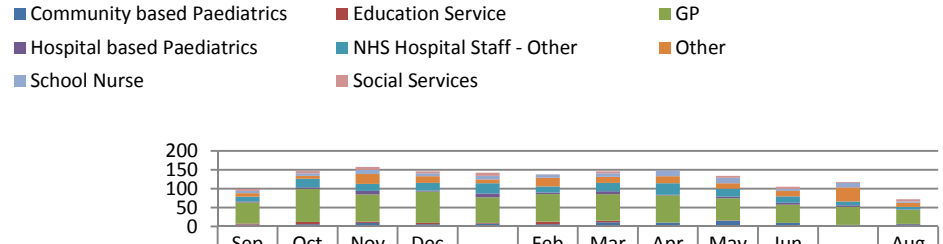
Referrals Received

Total Referrals Received



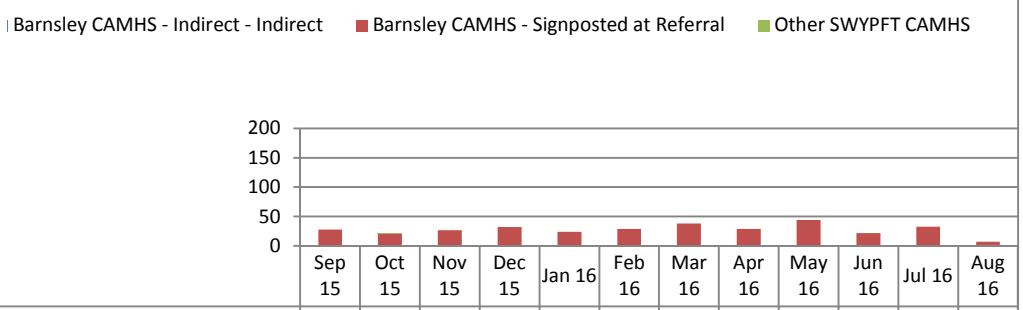
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Other SWYPFT CAMHS		1	5			2	2		2	1	1	2
Barnsley CAMHS	99	146	153	146	142	136	144	148	132	104	117	70

Referrals Received by Source



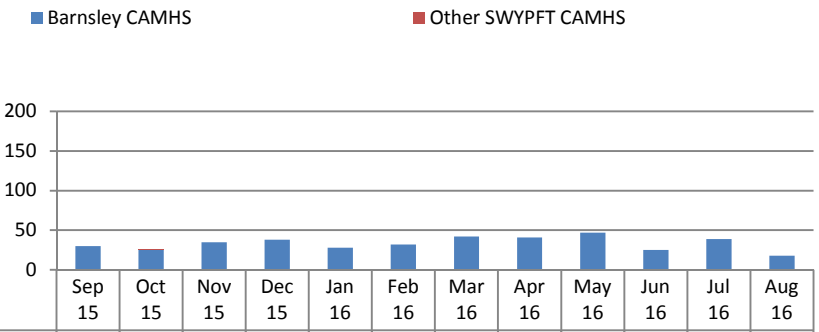
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Social Services	5	6	8	5	8	1	5		5	6	3	6
School Nurse	6	7	11	8	9	8	10	15	15	5	12	3
Other	9	8	26	18	11	23	16	19	14	14	37	11
NHS Hospital Staff - Other	13	23	19	20	27	16	22	30	21	17	10	7
Hospital based Paediatrics	2	4	9	3	10	4	7	2	4	5	4	1
GP	56	87	72	83	68	73	71	72	59	49	48	37
Education Service	3	6	4	3	1	7	4		1			1
Community based Paediatrics	5	6	9	6	8	6	11	10	15	9	4	6

Signposted Referrals



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Other SWYPFT CAMHS		1										
Barnsley CAMHS - Signposted at Referral	28	21	27	32	24	29	38	29	44	22	33	5
Barnsley CAMHS - Indirect - Indirect												2

Inappropriate Referrals



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Other SWYPFT CAMHS		1										
Barnsley CAMHS	30	25	35	38	28	32	42	41	47	25	39	18

Referrals Received Cont.

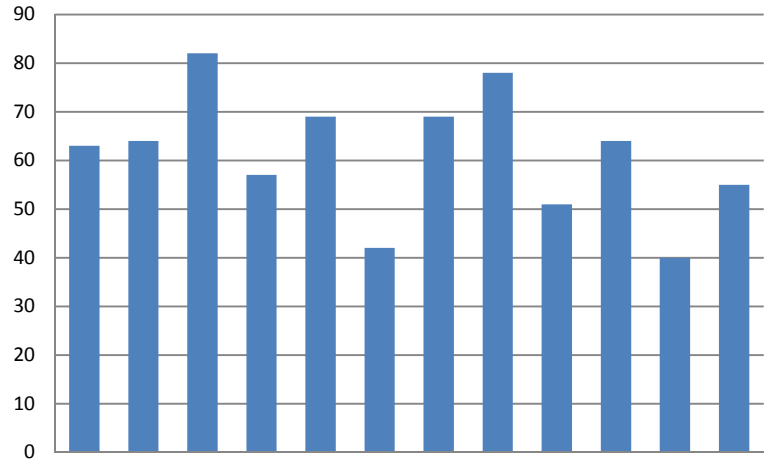
Description: Description:
Referrals received includes all referral sources, urgencies and inappropriate referrals.
Total inappropriate referrals includes all referrals marked as "inappropriate","inappropriate advice/liaison given" or "inappropriate (signposted)" upon discharge. This could be done as soon as the referral comes in to the service or may happen after the initial or choice appointment. It does not include any clients where they have been signposted to another organisation/agency after treatment with the service.
Signposted referrals are a subset of the total inappropriate referrals.

Comments: Signposted/Inappropriate referrals include referrals from previous months dependent upon time seen i.e. rejected from Choice/Initial Assessment, etc Also Inappropriate total included those signposted.

Signposted Referrals for Aug 16 - 5 were all signposted at point of referral, they have not had a face to face contact.

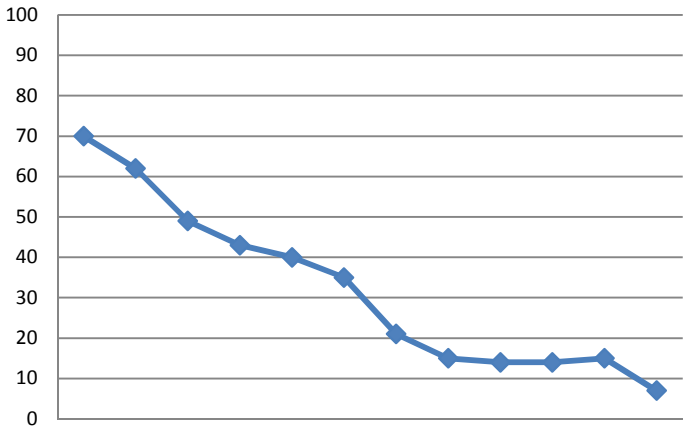
Assessment (Choice)

Total Choice Contacts



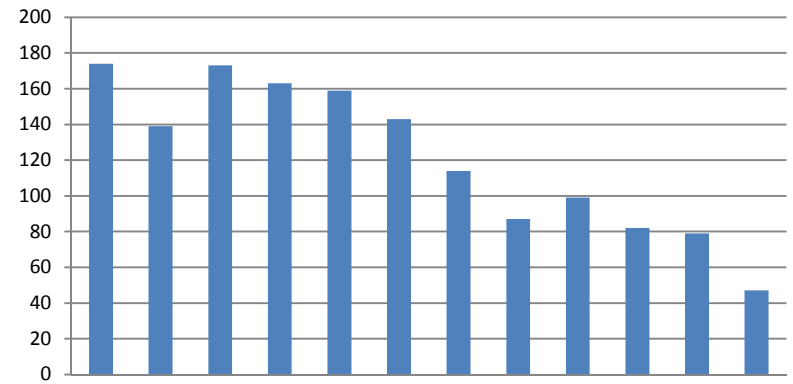
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley CAMHS	63	64	82	57	69	42	69	78	51	64	40	55

Average Wait to Next Available Clinic Slot



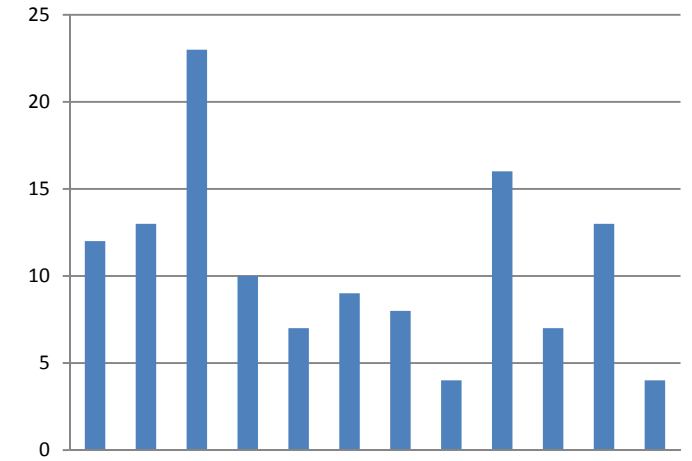
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley CAMHS	70	62	49	43	40	35	21	15	14	14	15	7

Total Referrals Waiting for Choice Contact



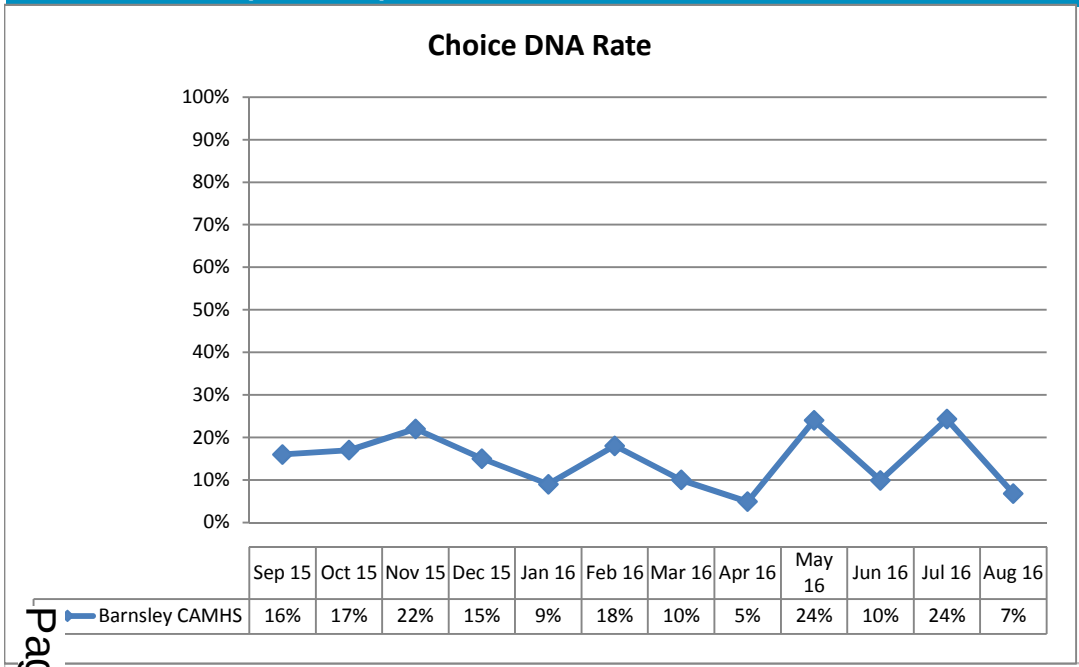
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley CAMHS	174	139	173	163	159	143	114	87	99	82	79	47

Choice DNA



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley CAMHS	12	13	23	10	7	9	8	4	16	7	13	4

Assessment (Choice) Cont.



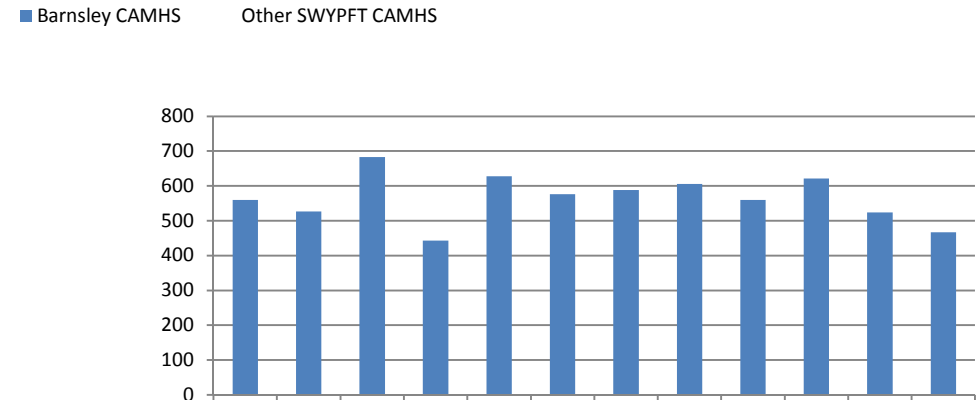
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley CAMHS	16%	17%	22%	15%	9%	18%	10%	5%	24%	10%	24%	7%

cription:
Total number of assessment (Choice) contacts reflects all choice contacts where the client attended that have an outcome attached to them.
e average wait is given in days. Please note that whilst appointments may be available, clients may choose an appointment that suits them better outside of 4 weeks.
The total referrals waiting for assessment (Choice) is a snapshot at month end; these clients could have a Choice appointment booked but not yet attended.

Comments:
The next available appointments as at 14/09/2016:
1. New Street - 22/09/16
2. Grimesthorpe 20/09/16
3. Hoyland 21/09/16

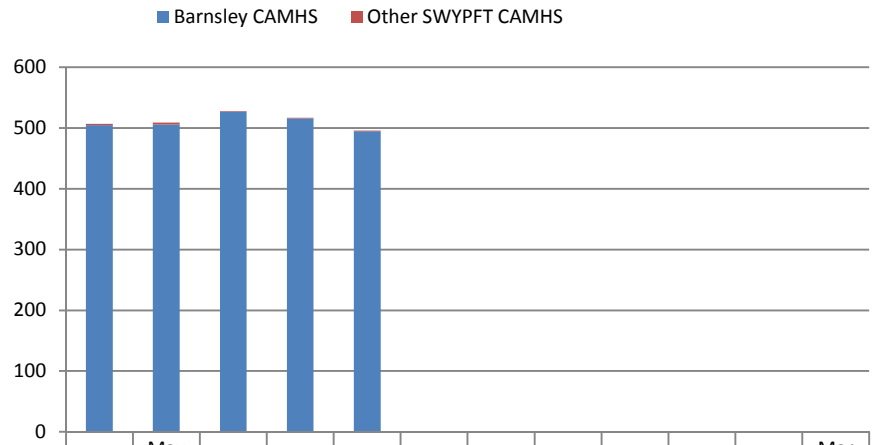
Treatment (Partnership) Contacts

Total Partnership Contacts



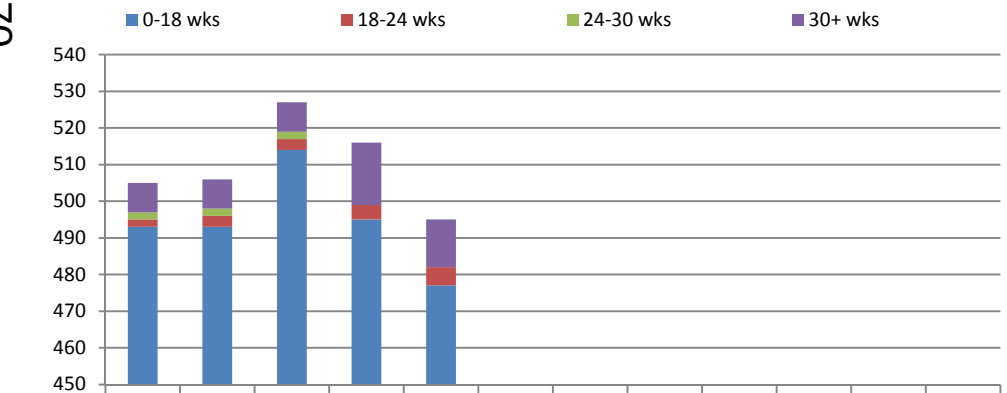
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Other SWYPFT CAMHS	3	7	4	5	4	5	3	10	7	3	1	
Barnsley CAMHS	560	527	683	443	628	576	588	606	560	621	524	467

Total Waiting



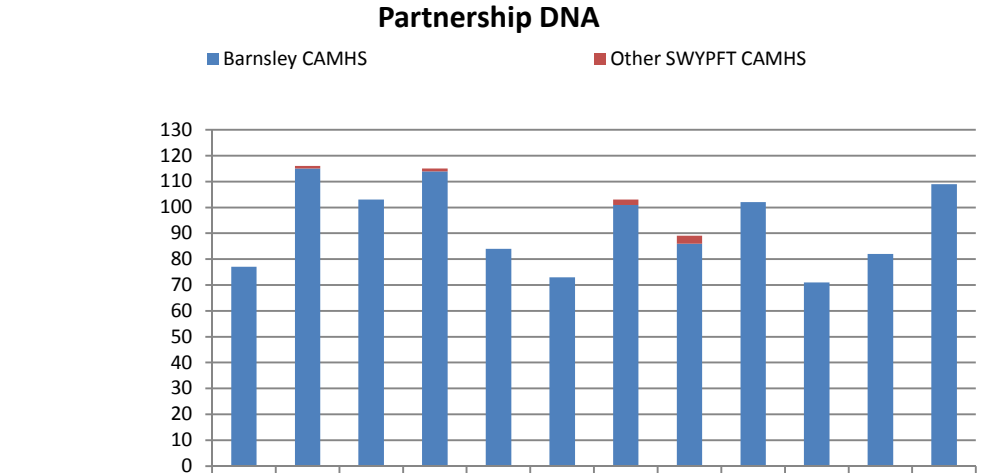
	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Other SWYPFT CAMHS	2	3	1	1	1							
Barnsley CAMHS	505	506	527	516	495							

Partnership Current Waits - Barnsley CAMHS

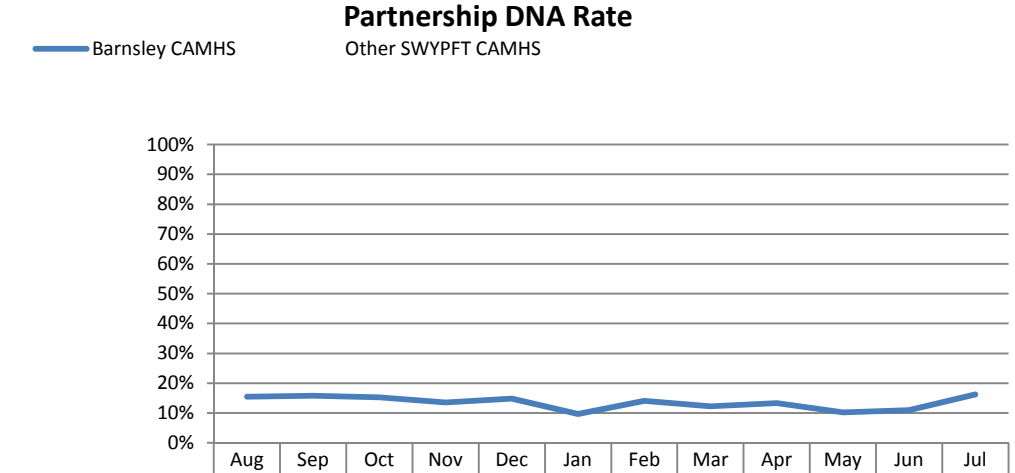


	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
30+ wks	8	8	8	17	13							
24-30 wks	2	2	2									
18-24 wks	2	3	3	4	5							
0-18 wks	493	493	514	495	477							

Treatment (Partnership) Contacts



	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16
Other SWYPFT CAMHS	0	1	0	1	0	0	2	3	0	0	0	0
Barnsley CAMHS	77	115	103	114	84	73	101	86	102	71	82	109



	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16
Barnsley CAMHS	15%	16%	15%	14%	15%	10%	14%	12%	13%	10%	11%	16%
Other SWYPFT CAMHS	0%	25%	0%	20%	0%	0%	29%	38%	0%	0%	0%	0%

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scription:
: total treatment (Partnership) contacts includes all outcomed treatment contacts.
: total waiting for treatment (Partnership) and current waits by time band are a snapshot at month end.
The average length of wait to treatment (Partnership) is a year to date position in days based on clients who have had their first treatment contact (referral receipt date to date of 1st treatment contact).
DNA = Client did not attend.

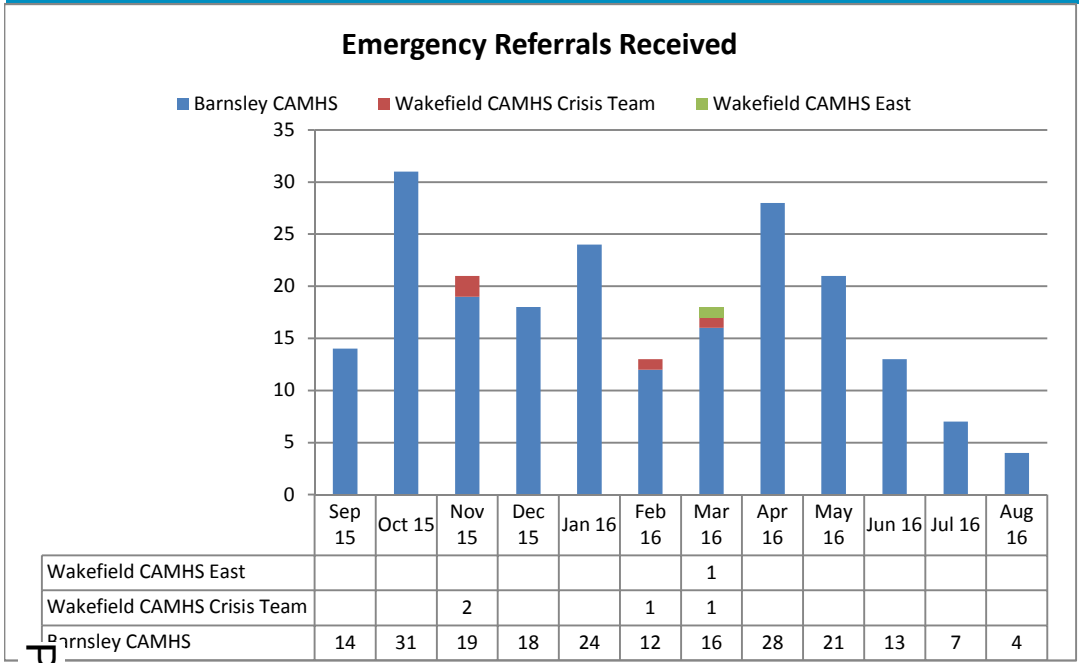
Comments: The pathway and MDT process are currently being implemented across the service. From the 1st June the pathway MDT will begin reviewing/prioritising and allocating the waiting lists with a view that all processes to be fully implemented by the end September 2016.

Other SWYPFT CAMHS data relates to clients previously with an address, and/or GP, from other SWYPFT CAMHS area's

There are no ASD for the Partnership information. The total waiting includes ADHD clients of which it is estimated to be a minimum of 150 clients from the Complex behaviour Pathway.

The Service is undertaking a data quality activity regarding a number of appointments that have not yet had an outcome recorded in the system.

Emergency Referrals



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Wakefield CAMHS East							1					
Wakefield CAMHS Crisis Team			2			1	1					
Barnsley CAMHS	14	31	19	18	24	12	16	28	21	13	7	4

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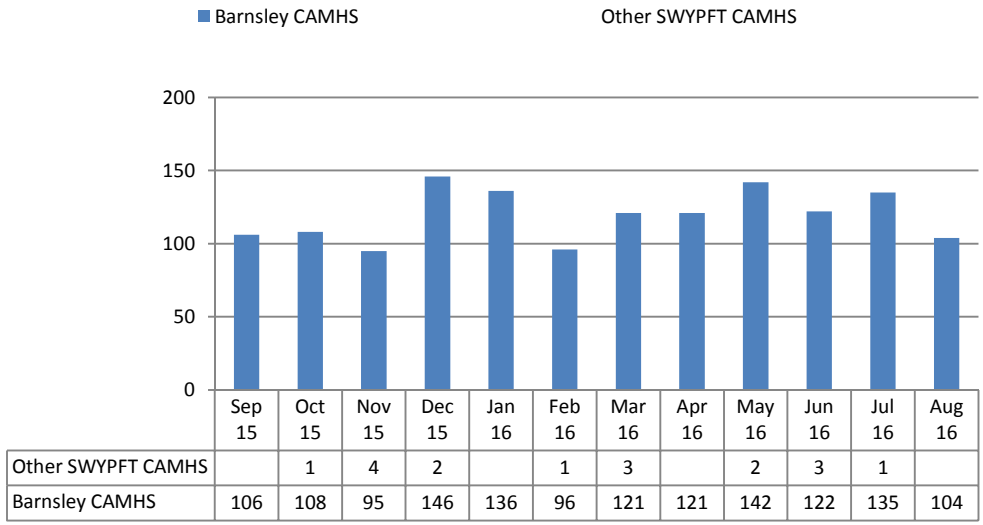
scription:
ergency Referrals Received counts any referral with an urgency of "Emergency".

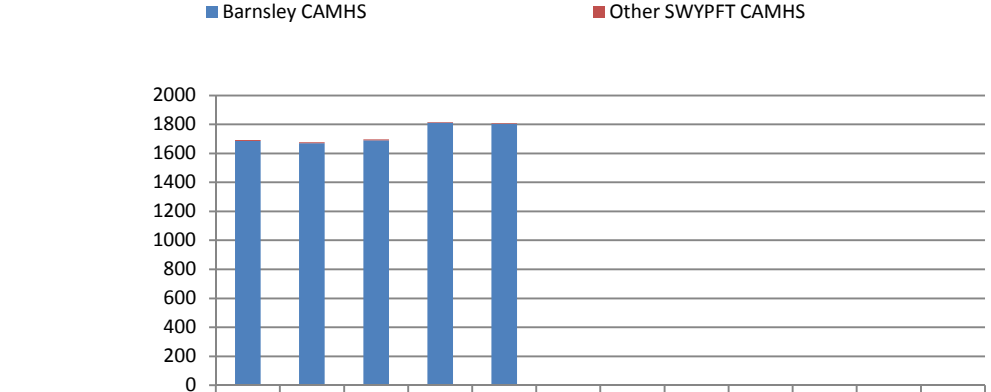
mments: Other SWYPFT CAMHS data relates to clients previously with an address, and/or GP, from other SWYPFT CAMHS area's.

In August there were an additional 7 that are believe to be Face to face contacts and total Duty = 13 inc telephone contact.
There is a delay in the duty (emergency daytime) contacts/referrals being inputted on to RiO.

Other Information



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Other SWYPFT CAMHS		1	4	2		1	3		2	3	1	
Barnsley CAMHS	106	108	95	146	136	96	121	121	142	122	135	104



	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Other SWYPFT CAMHS	8	7	5	4	4							
Barnsley CAMHS	1685	1669	1691	1812	1802							

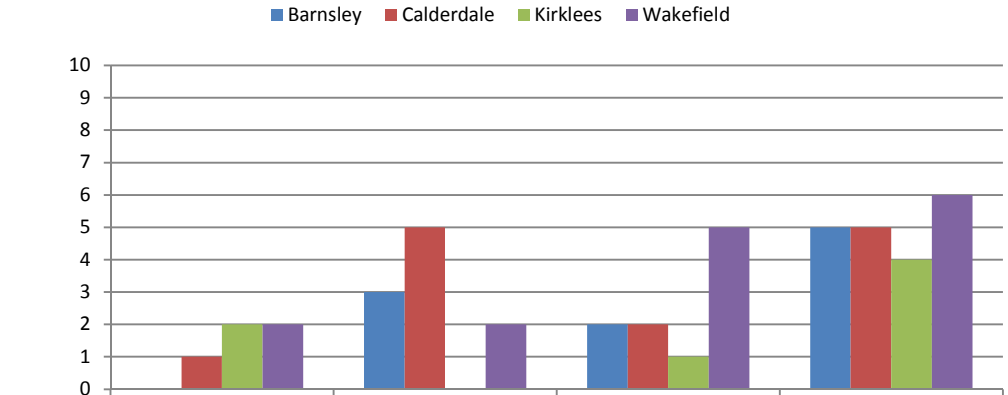
cription: Total Discharges and Total caseload.

nments: Other SWYPFT CAMHS data relates to clients previously with an address, and/or GP, from other SWYPFT CAMHS area's

The total caseload includes those children waiting for an ASD assessment who were accepted when the pathway was hosted by Barnsley CAMHS. As at the end of June this totalled 96 cases of which 48 have been waiting over 12 months. The service has 43 assessments in progress or with appointments booked to start assessment in July. The service continues to offer the Cygnet carer support programme and due to demand plan to offer 2 groups in the Autumn to meet demand.

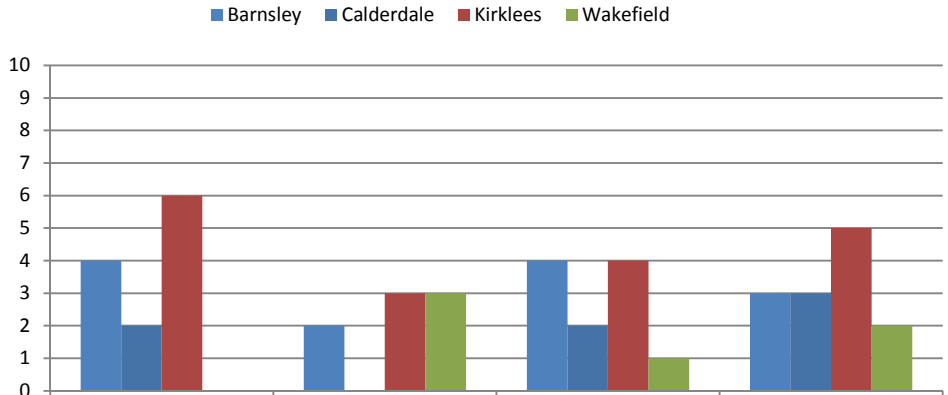
Patient Experience

Total Compliments



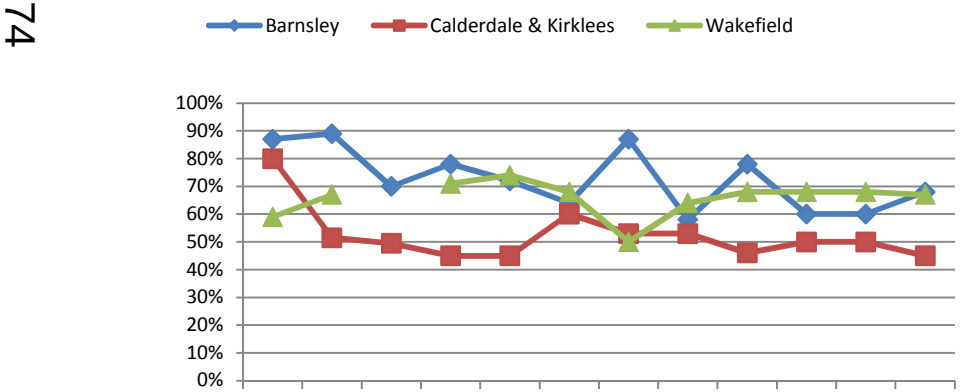
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	0	3	2	5
Calderdale	1	5	2	5
Kirklees	2	0	1	4
Wakefield	2	2	5	6

Total Complaints



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	4	2	4	3
Calderdale	2	0	2	3
Kirklees	6	3	4	5
Wakefield	0	3	1	2

% People Extremely Likely or Likely to Recommend Place of Care



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	87%	89%	70%	78%	72%	64%	87%	58%	78%	60%	60%	68%
Calderdale & Kirklees	80%	52%	50%	45%	45%	60%	53%	53%	46%	50%	50%	45%
Wakefield	59%	67%		71%	74%	68%	50%	64%	68%	68%	68%	67%

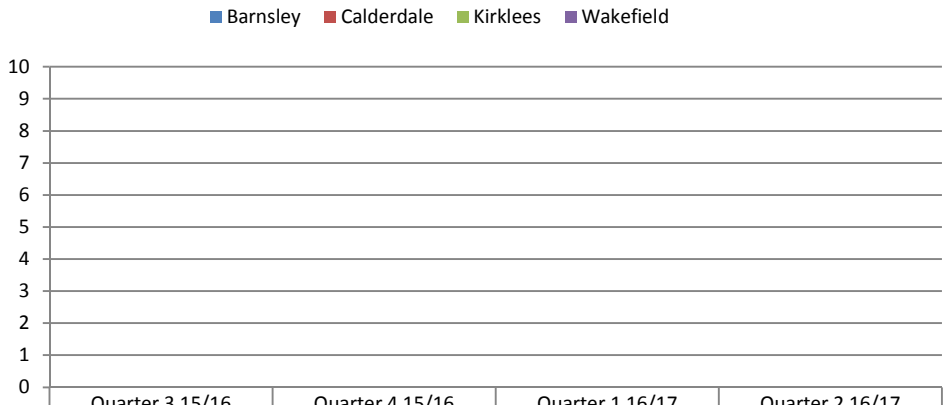
Patient Experience cont.

Description:
The number of Information Governance breaches as reported on SWYPFT's DATIX system.
The total number of compliments per quarter that are logged with SWYPFT customer services team. There is no goal for this indicator. Data is representative of quarter to date.
The total number of complaints per quarter that are logged with SWYPFT customer services team. There is no goal for this indicator.
Data is representative of quarter to date.
The percentage of people who are 'Extremely likely ' or 'Likely' to recommend our services to their family and friends as a place to receive care and treatment (National FFT question).

Comments:

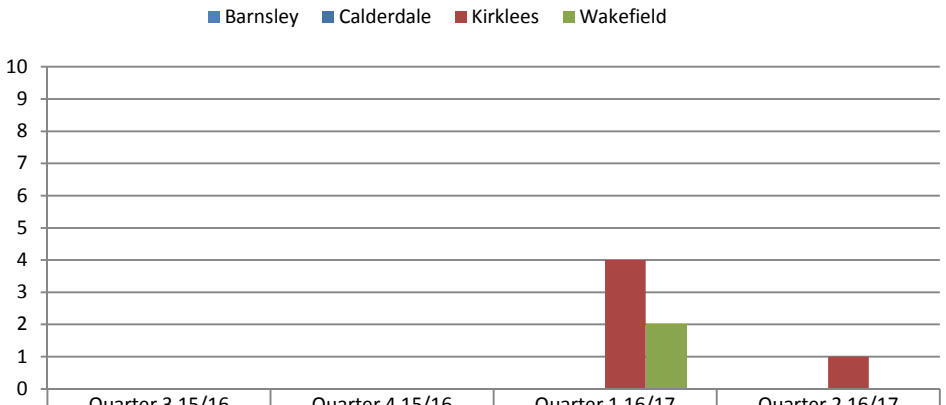
Patient Safety

Admissions of Under 16s to Adult Wards



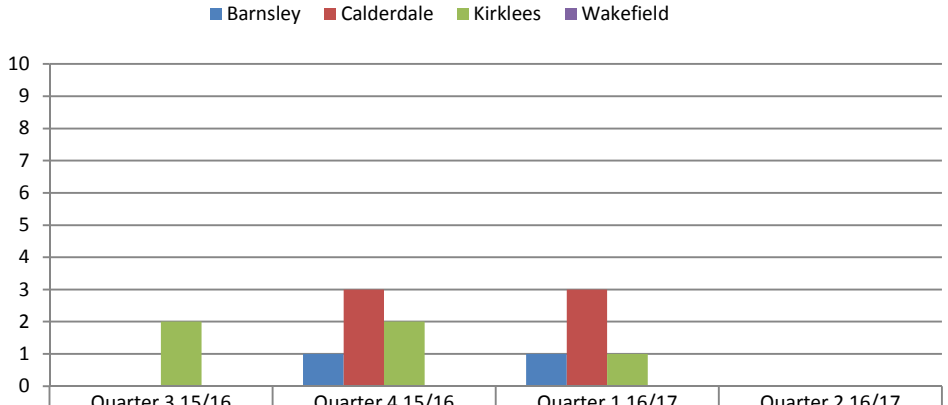
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	0	0	0	0
Calderdale	0	0	0	0
Kirklees	0	0	0	0
Wakefield	0	0	0	0

Admissions of 16 & 17 Year Olds to Adult Wards



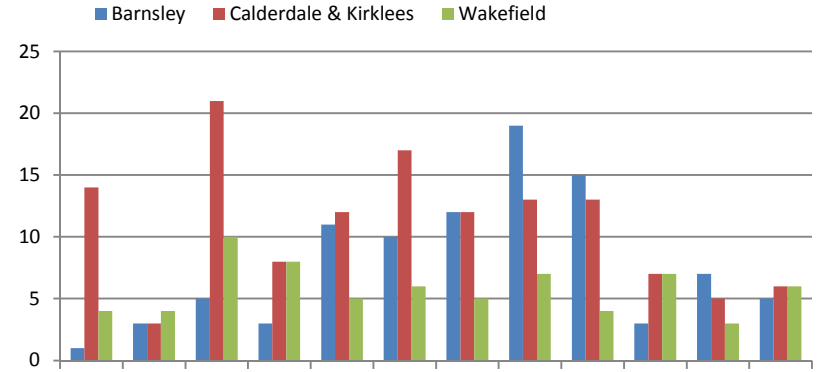
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	0	0	0	0
Calderdale	0	0	0	0
Kirklees	0	0	4	1
Wakefield	0	0	2	0

Serious Incidents



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	0	1	1	0
Calderdale	0	3	3	0
Kirklees	2	2	1	0
Wakefield	0	0	0	0

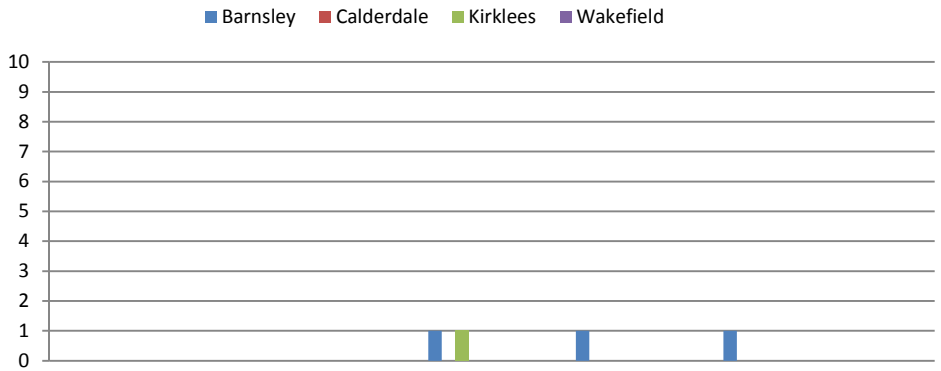
Incidents - All Grades & Severity



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	1	3	5	3	11	10	12	19	15	3	7	5
Calderdale & Kirklees	14	3	21	8	12	17	12	13	13	7	5	6
Wakefield	4	4	10	8	5	6	5	7	4	7	3	6

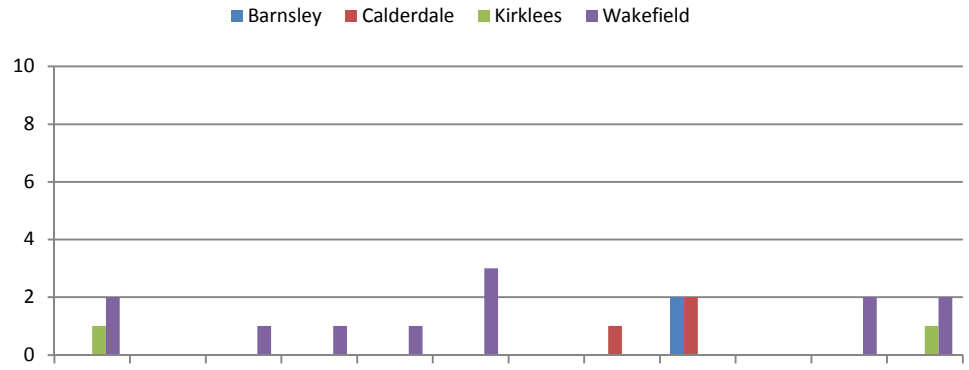
Patient Safety Cont.

Duty of Candour Incidents



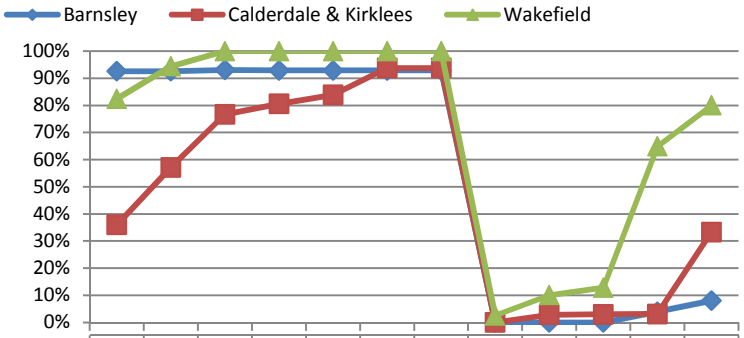
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	0	0	0	0	0	1	0	1	0	1	0	0
Calderdale	0	0	0	0	0	0	0	0	0	0	0	0
Kirklees	0	0	0	0	0	1	0	0	0	0	0	0
Wakefield	0	0	0	0	0	0	0	0	0	0	0	0

Assessments Under Section 136 (MHA, 1983)



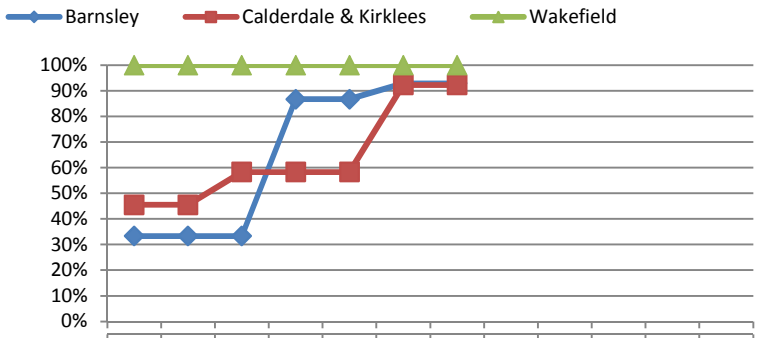
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	0	0	0	0	0	0	0	0	2	0	0	0
Calderdale	0	0	0	0	0	0	0	1	2	0	0	0
Kirklees	1	0	0	0	0	0	0	0	0	0	0	1
Wakefield	2	0	1	1	1	3	0	0	0	0	2	2

Percentage of Staff Having Received an Appraisal - Band 6 & Above



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	93%	93%	93%	93%	93%	93%	93%	0%	0%	0%	4%	8%
Calderdale & Kirklees	36%	57%	77%	81%	84%	94%	94%	0%	3%	3%	3%	33%
Wakefield	82%	94%	100%	100%	100%	100%	100%	3%	10%	13%	65%	80%

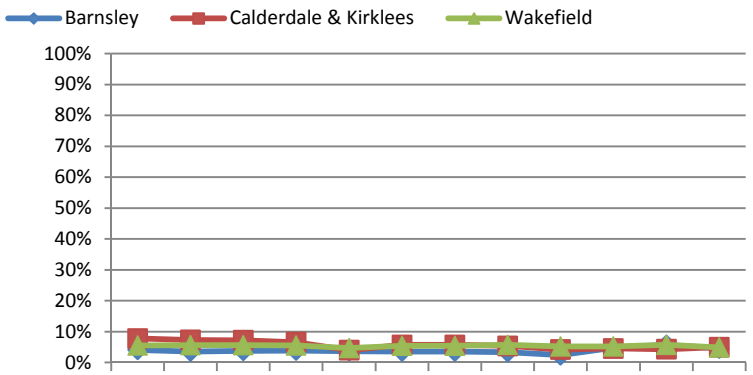
Percentage of Staff Having Received an Appraisal - Band 5 and below



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	33%	33%	33%	87%	87%	93%	93%					
Calderdale & Kirklees	46%	46%	58%	58%	58%	92%	92%					
Wakefield	100%	100%	100%	100%	100%	100%	100%					

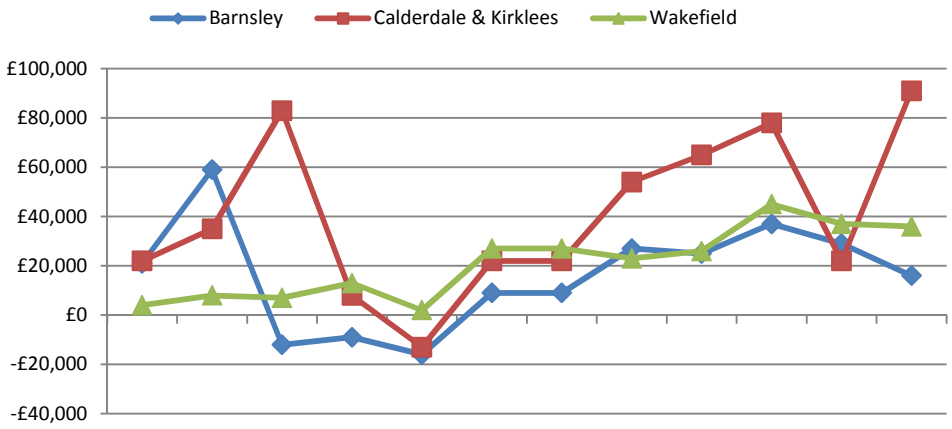
Patient Safety Cont.

Sickness Rate



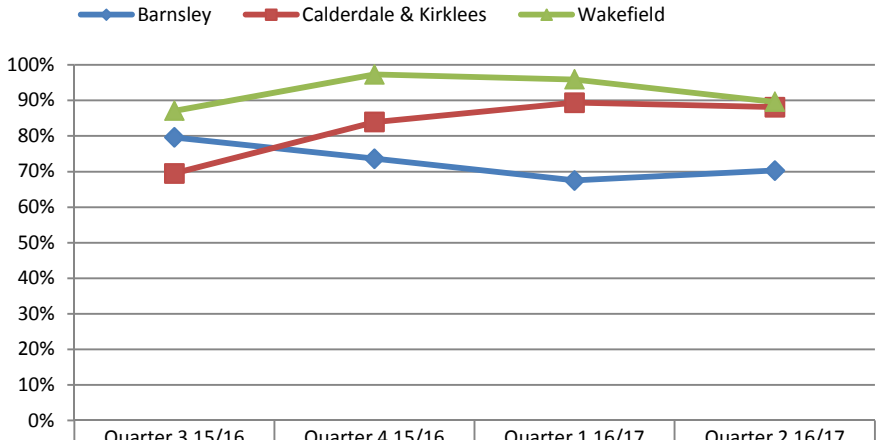
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	4%	4%	4%	4%	4%	4%	4%	3%	2%	5%	6%	5%
Calderdale & Kirklees	8%	7%	7%	7%	4%	6%	6%	5%	4%	5%	4%	5%
Wakefield	6%	6%	6%	6%	5%	5%	5%	6%	5%	5%	6%	5%

Agency Staff Usage



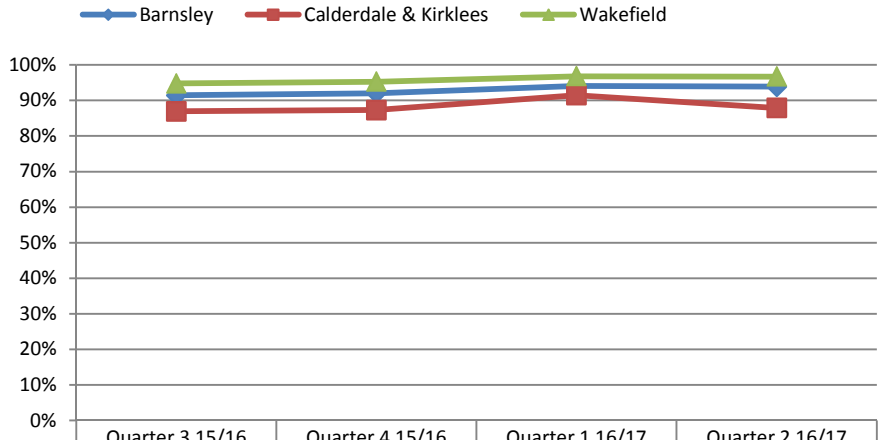
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	£21,000	£59,000	-£12,000	-£9,000	-£16,000	£9,000	£9,000	£27,000	£25,000	£37,000	£29,000	£16,000
Calderdale & Kirklees	£22,000	£35,000	£83,000	£8,000	-£13,000	£22,000	£22,000	£54,000	£65,000	£78,000	£22,000	£91,000
Wakefield	£4,000	£8,000	£7,000	£13,000	£2,000	£27,000	£27,000	£23,000	£26,000	£45,000	£37,000	£36,000

Mandatory Training - Aggression Management



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	80%	74%	68%	70%
Calderdale & Kirklees	70%	84%	89%	88%
Wakefield	87%	97%	96%	90%

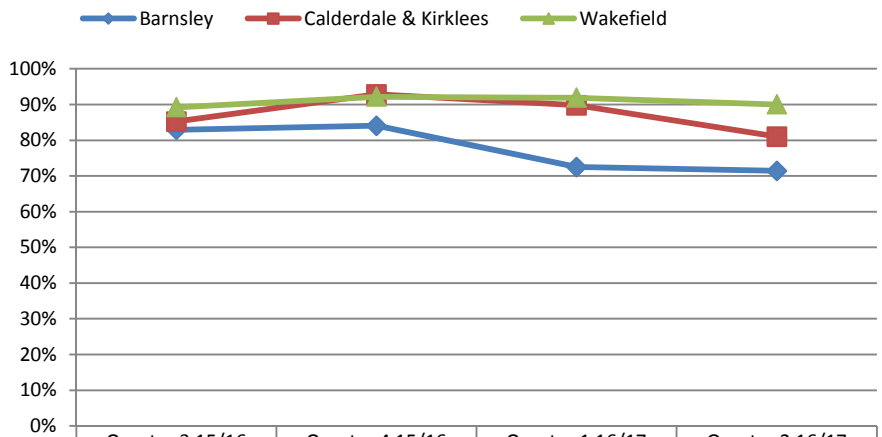
Mandatory Training - Equality & Diversity



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	91%	92%	94%	94%
Calderdale & Kirklees	87%	87%	92%	88%
Wakefield	95%	95%	97%	97%

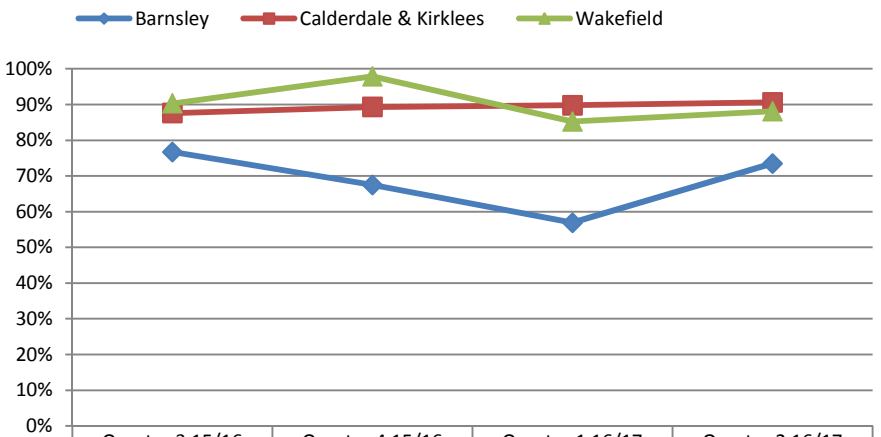
Patient Safety Cont.

Mandatory Training - Fire Safety



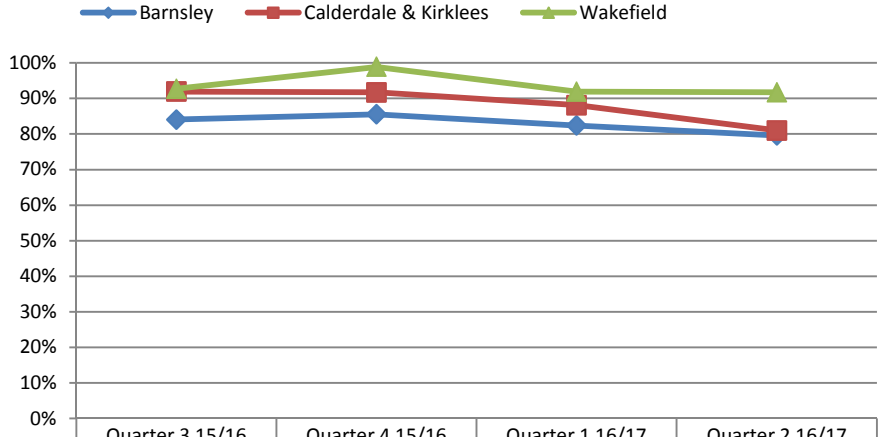
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	83%	84%	73%	71%
Calderdale & Kirklees	85%	93%	90%	81%
Wakefield	89%	92%	92%	90%

Mandatory Training - Infection Control & Hand Hygiene



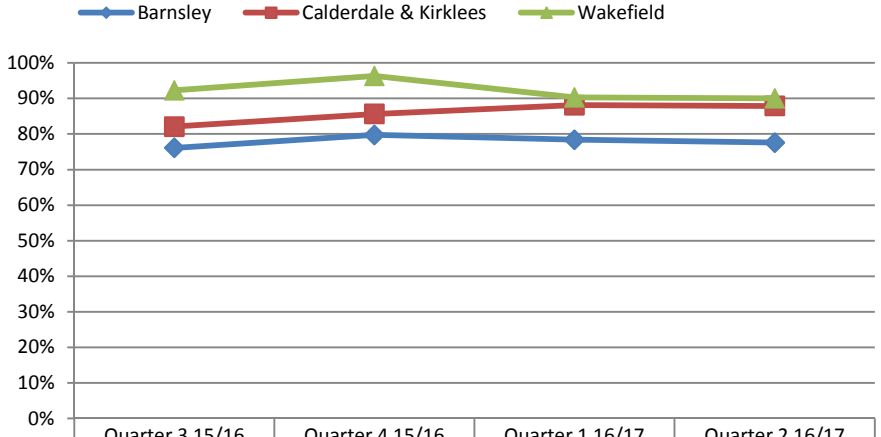
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	77%	68%	57%	74%
Calderdale & Kirklees	88%	89%	90%	91%
Wakefield	90%	98%	85%	88%

Mandatory Training - Information Governance



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	84%	86%	82%	80%
Calderdale & Kirklees	92%	92%	88%	81%
Wakefield	93%	99%	92%	92%

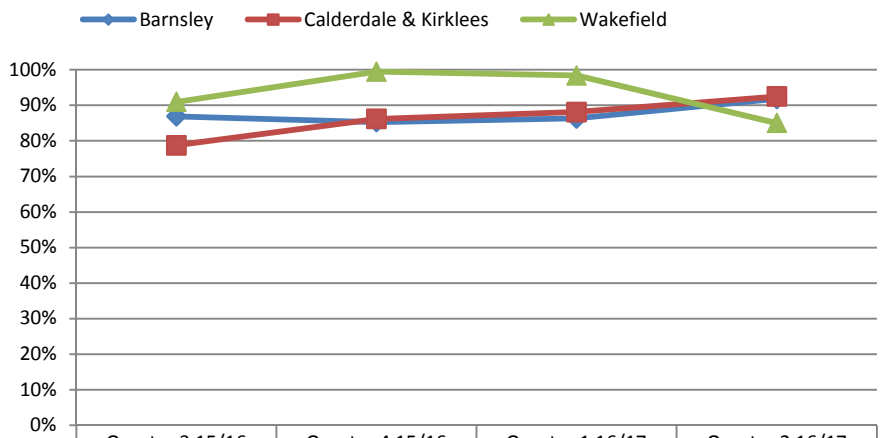
Mandatory Training - Moving & Handling



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	76%	80%	78%	78%
Calderdale & Kirklees	82%	86%	88%	88%
Wakefield	92%	96%	90%	90%

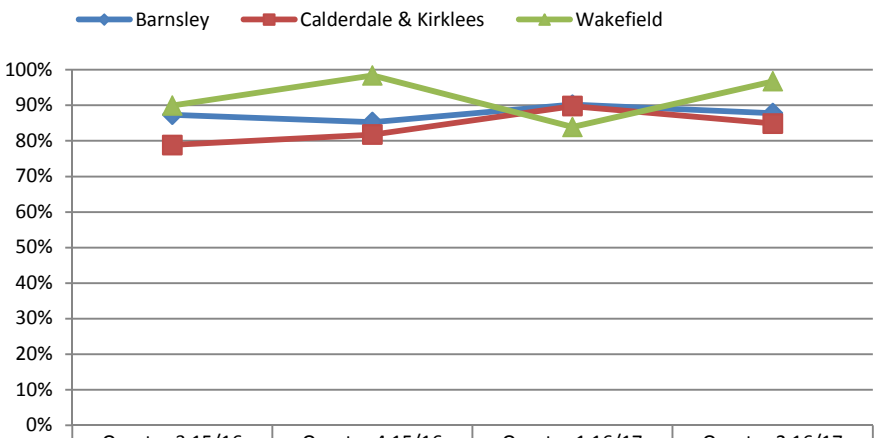
Patient Safety Cont.

Mandatory Training - Safeguarding Adults



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	87%	85%	86%	92%
Calderdale & Kirklees	79%	86%	88%	93%
...kefield	91%	99%	98%	85%

Mandatory Training - Safeguarding Children



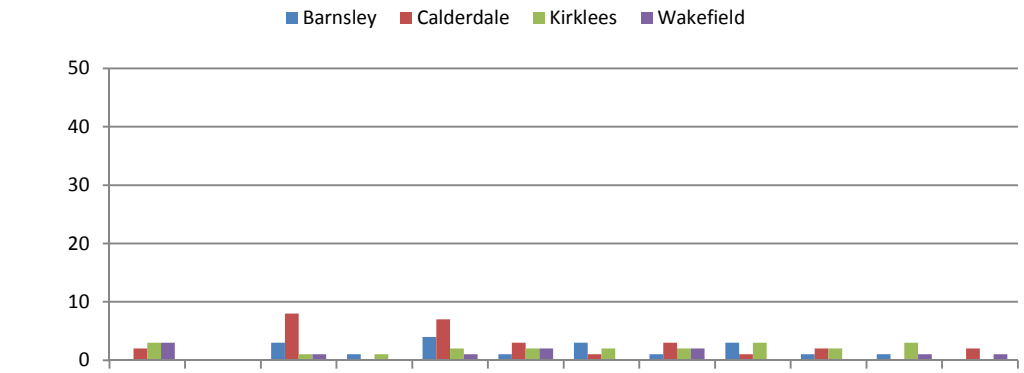
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	87%	85%	90%	88%
Calderdale & Kirklees	79%	82%	90%	85%
Wakefield	90%	98%	84%	97%

D...iption: The number of admissions of children, under the age of 16, into SWYPFT's adult wards. Data is representative of quarter to date.
T... umber of admissions of children, aged 16 or 17, into SWYPFT's adult wards. Data is representative of quarter to date.
T... umber of serious incidents graded amber or red as reported on SWYPFT's DATIX system- this is not exclusively STEIS reportable incidents. Data is representative of quarter to date.
The total number of incidents reported on DATIX, by grade.
Duty of candour - incidents where we recognise that our care or treatment may have an impact on a person in terms of harm. Data is representative of quarter to date.
The number of assessments (for age 17 and under) that have taken place under section 136 of the Mental Health Act. Data is representative of quarter to date.
The number of staff , band 6 and above who have received an appraisal . Goal is 90% by end of Q1. Data is re-set at end of March.
The number of staff , band 5 and below who have received an appraisal. Goal is 90% by Q2. Data is re-set at end of March.
The percentage of staff who are absent from work as a result of illness. The figures above represent a year to date percentage. Goal is 4%
Agency expenditure by service line.
Aside from Information Governance (95%), all mandatory training targets are based on achieving 80% at year end.

Comments: Percentage of staff having received an appraisal for Band 5 and below - the data will not be available until after September 16.

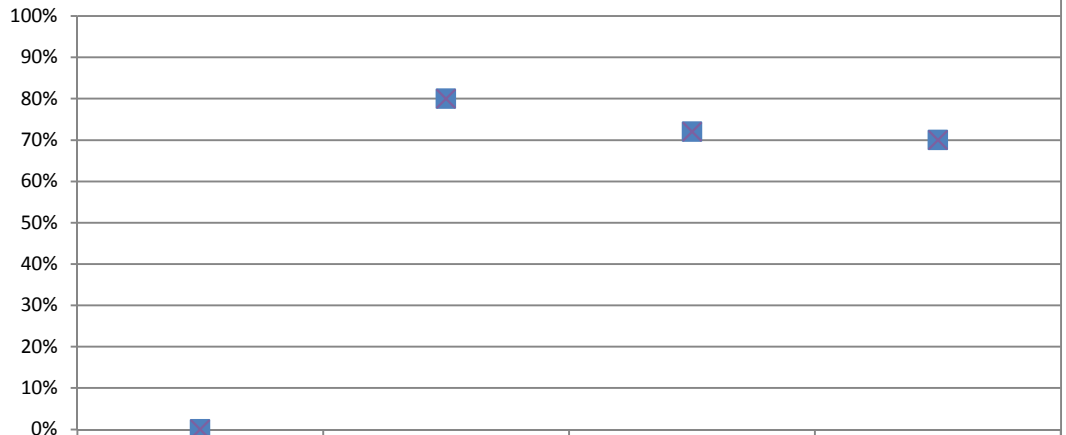
Clinical Effectiveness

Information Governance Breaches



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	0	0	3	1	4	1	3	1	3	1	1	0
Calderdale	2	0	8	0	7	3	1	3	1	2	0	2
Kirklees	3	0	1	1	2	2	2	2	3	2	3	0
Wakefield	3	0	1	0	1	2	0	2	0	0	1	1

% of Staff Recommending SWYPFT as a Place for Care



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Total	0%	80%	72%	70%

Description:
The number of Information Governance breaches as reported on SWYPFT's DATIX system.
The percentage of staff who would recommend our services as a place for care and treatment. Data was sourced from the Staff Friends and Family Test administered through a staff communication and engagement survey.

Comments:

Future in Mind - 5 year Funding Allocation

WORK-STREAM PRIORITY	FiM Investment Year 1 2015/16 £	FiM Investment Year 2 2016/17 £	FiM Investment Year 3 2017/18 £	FiM Investment Year 4 2018/19 £	FiM Investment Year 5 2019/2020 £
1. Developing a Community based Eating Disorder Service (Collaborative arrangement with Calderdale, Wakefield, Greater Huddersfield and Kirkless CCG's)	146,000	143,000			
2. Building resilience in Primary School Children (THRIVE) (Public Health led)	111,000	98,000			
3. School-led mental health therapeutic team (Springwell Academy taking the lead - based on the Stockport model)	145,000	335,500 (Incorproates Peer Mentoring work undertaken by Chilypep plus training provided by TADS /SYEDA)			
4. CAMHS: SPA / YOT (CAMHS is provided by South West Yorkshire Partnership NHS Foundation Trust)	60,000	103,500			
5. Training Young Commissioners (Led by Chilypep)	30,000	20,000			
6. Accessing information ('One-stop- shop') (Led by YOT Manager)	20,000	0			
TOTAL INVESTMENT	**512,000**	**710,000**			

BARNSLEY COLLEGE EMOTIONAL WELLBEING PILOT PROJECT REPORT 2015

This report evaluates the impact of Chilypep's early intervention and prevention pilot programme within Barnsley College, commissioned by Barnsley CCG from 1st November 2014-31st July 2015.

The report also acts as a 'how to' guide for those looking to implement a 'whole school or college approach' to emotional wellbeing, providing useful hints and tips that we have picked up along the way!

CHILYPEP
Children & Young People's Empowerment Project

NHS
Barnsley Clinical Commissioning Group

Barnsley College
Together We Achieve

CONTENTS

Contact Details

If you would like more information about Chilypep and the work we do we would love to hear from you!

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EXECUTIVE SUMMARY

From 1st November 2014 to 31st July Chilypep (The Children and Young People's Empowerment Project) worked with Barnsley College to pilot an early intervention and prevention project within Barnsley College.

RATIONALE

School and college is where young people spend a lot of their time and, with 1 in 10 young people in every classroom having a diagnosable mental health problem, schools and colleges have a major role to play around **early intervention and prevention**. We know that mental health runs along a continuum and that we can often prevent young people from reaching crisis if they are able to access support early on. Giving young people the **space and time to explore** their own emotional wellbeing in a safe and supportive environment is therefore vital if we are to create a **culture of wellbeing** within schools and colleges. Then and only then can we make a sea change in attitudes, perceptions and responses around mental health.

METHODOLOGY AND KEY ACHIEVEMENTS

The project aimed to build the resilience of students within college to be able to support themselves and others around their mental health, as well as increasing the confidence of college staff to be able to recognise the signs of mental ill health amongst students and have conversations with them around mental health. By adopting a 'Whole College Approach' to mental health we aimed to normalise conversations and discussions around mental health, giving 'mental health' visibility within college, and destigmatising mental ill health.

What do we mean by the term 'mental health'?

Chilypep has worked with young people over the years to look at definitions of mental health and what this term means to them. Young people have highlighted the importance of viewing mental health across a continuum; mental health is in this sense something that we all have and it can be positive or negative. We might live with a diagnosed mental illness and experience positive mental health. Equally we all have the potential to experience 'mental ill health' even with no diagnosable mental illness, and again this operates on a continuum. Our ability to 'bounce back' from periods of mental ill health can often depend on the coping mechanisms and support we have in place as well as our 'resilience'.

Throughout this report 'mental health' and 'emotional wellbeing' are both used somewhat interchangeably.

Chilypep's 'Whole College Approach' to emotional wellbeing focused on three core areas of work:

1. **Mental Health Awareness:** Building the resilience of young people through the delivery of mental health educational workshops and tutorials across college sites

Chilypep's research with young people has highlighted that they would like to see opportunities created for young people to talk, and learn, about emotional wellbeing and mental health within school and college settings. Over the course of the pilot we Reached 265 students through the delivery of 50 mental health awareness workshops. Following tutorial evaluations young people often quoted changes in their perceptions of mental health, such as *"I've learnt that mental health is something everyone has, it can be good or bad just like our physical health".* This would seem to indicate a change in perception around mental health, and a reduction in stigma following young people's involvement in college tutorials.

2. **Developing Peer Support Models:** Building the resilience of young people to manage their own mental health and support their peers through the development of Barnsley College 'Emotional Wellbeing (EWB) Champions'

Chilypep supports children and young people to develop positive mental health and emotional well-being, and promotes empowerment and participation practice as integral to supporting young people's positive mental health and emotional well-being. Through recruiting and training 10 young people with lived experiences around mental health as 'EWB Champions' young people were able to have a voice and influence in the project design and delivery; this in turn improved their own mental health and increased their resilience and ability to cope when things were affecting them. By the end of the project 100% showed an increase in their sense of wellbeing, quoting that they felt good about themselves more often as the project went on.

"Before I started 'EWB Champions', I didn't feel like I could talk to anyone. Now I find that I have a number of people I can talk to and they can also talk to me."

"This project has helped me to manage my stress and anxiety, allowing me to share my experiences with others to help them."

Chilypep actively promote Peer Mentoring approaches because we have found that:

- Young people tend to engage better with other young people than with older adults
- Our EWB Champions use engaging tools and approaches designed by them to ensure they capture the interest of young people
- The stigma around mental health problems means that this can be a difficult subject to discuss unless you feel shared interests and experiences with the facilitator as you do with a peer-facilitator.
- EWB Champions get access to training and support from Chilypep increasing their confidence, resilience and skill base.

- The college or school becomes a healthier place for students to be, improving the college environment for both staff and young people, whilst supporting the education and attainment of pupils.

3. **Staff training and development:** Building the knowledge, understanding and confidence of staff to enable them to respond to students' mental health and emotional wellbeing needs

The project aimed to create a culture of empathy, non-judgment, and support within the college environment. We did this by building the skills and confidence within staff teams to enable them to speak to young people about their mental health. Chilypep delivered mental health awareness training to 18 front facing college staff, 95% of whom reported an increased understanding around youth mental health following the workshop, and 73% reporting increased confidence in supporting young people around their mental health. We then went on to train 12 college staff members in Youth Mental Health First Aid. Following the training 100% reported increased confidence in supporting young people around their mental health, and similarly 100% reported a significant increase in their knowledge and understanding around youth mental health.

RECOMMENDATIONS

Education and Awareness

1. Embed an interactive and engaging educational offer that involves young people from the start
2. Establish a safe and supportive environment where students can openly explore mental health and emotional wellbeing
3. Encourage and enable peer to peer learning
4. Work with young people to co-design services

Peer Support Models

1. Involve young people from the start
2. Provide training to support young people's involvement
3. Take the time for young people to learn about mental health and emotional wellbeing and develop their own resilience and coping strategies
4. Be flexible and enable young people to steer their own project developments
5. Ensure there is sufficient capacity and resources in place to sustain young people's meaningful involvement

Staff Training and Development

1. Put in place an ongoing mental health and emotional wellbeing training offer to school and college staff
2. Enable effective information and signposting for young people
3. Involve young people in the recruitment and training of staff
4. Encourage joined up working

BACKGROUND

Chilypep were commissioned by Barnsley CCG to pilot an **early intervention and prevention programme** with Barnsley College from 1st November 2014 to 31st July 2015. This report details the work undertaken by Chilypep throughout the pilot period, and an evaluation of the **impact** of this work. Whilst the pilot took part within a college setting this model could be readily transferred across to a school setting. This report therefore acts as a **'how to'** guide for professionals working to establish a **whole school or college approach** to emotional wellbeing, containing **hints and tips** and **key learning** gained from the pilot.

ABOUT CHILYPEP

The Children and Young People's Empowerment Project works alongside children and young people aged 8 to 25, to find fun and creative ways of involving them in the decisions that affect their lives and to build their confidence, skills and abilities. This develops their personal, social and emotional skills, raises their aspirations and helps them to achieve their potential.

Chilypep is a nationally registered charity based in Sheffield where the majority of our work has taken place. We have worked in some of the most disadvantaged areas of Sheffield and with some of the most hard to reach groups of children and young people, supporting them to make a positive contribution to their communities and neighbourhoods. Our models, tools and training techniques have been nationally recognised by the government and the National Youth Agency in published good practice guidance, national evaluations and in Sheffield City Council's Joint Area Review inspection.

Chilypep's aim is to ensure that children and young people are empowered to take more control of their own lives and choices, and can meaningfully participate in the

decisions that affect their lives as individuals, as receivers of services, and as members of their communities, neighbourhoods and the wider world. From one-off consultation events and long term participation projects, to strategic planning and policy development, our key principle is to work in partnership with children, young people and the organisations and agencies that affect them.

We support children and young people to develop positive mental health and emotional well-being, and promote empowerment and participation practice as integral to supporting young people's positive mental health and emotional well-being.

We were one of 2 delivery partners within the Sheffield Right Here programme. Right Here enabled both delivery partner organisations to develop and use a combination of therapeutic and youth work methods to engage and empower young people, by drawing on the expertise of emotional wellbeing and youth work and empowerment practice. Our premise is our belief that by actively practicing youth work principles across young people's services, young people's lives are improved and the relationships between decision-makers, workers and young people are transformed, something which young people have said is key. Right Here gave us the opportunity to explore and refine how this can work in practice, and to work with partner organisations to support them to develop a more participative youth work approach to mental health service development and delivery.

BARNSLEY COLLEGE EMOTIONAL WELLBEING PILOT PROJECT

NHS Barnsley Clinical Commissioning Group commissioned Chilypep to pilot an early intervention and prevention programme with Barnsley College from 1st November 2014 to 31st July 2015.

The pilot aims and objectives were:

- To product test a range of emotional wellbeing (EWB) interventions
- To investigate time, cost and resources required to replicate piloted interventions at scale across Barnsley and compile in reusable format for future developments
- To produce qualitative and quantitative evaluation of impact against attainment, attendance and self-reported EWB outcome measures (including resilience)
- To work collaboratively with existing EWB services, pastoral staff, College Youth Council etc. across all departments of Barnsley College to maximise impact and ensure full inclusion across all college sites
- To engage with students to understand their needs and issues and to develop innovative, effective and scalable solutions and interventions to address these
- To provide children and young people facing staff with skills and confidence to undertake Brief interventions (BI) for emotional wellbeing
- To develop and trial a range of training/awareness raising sessions to children and young people facing professionals in cross sector organisations
- To evaluate pre-post and follow up impact of training

NATIONAL/ LOCAL CONTEXT AND EVIDENCE BASE

One in ten children aged 5 to 16 have a clinically significant mental health problem. Approximately 50% of lifetime mental illness starts before the age of 14, and it is estimated that, potentially, half of these problems are preventable. With the right services and support early on, future health problems and onset of symptoms can be minimised.

60–70% of children and adolescents who experience clinically significant mental health problems have not been offered evidence-based interventions at the earliest opportunity. (Meltzer et al, 2003)

Prevention and intervention in emotional wellbeing and mental health targeted at children and young people will result in greater benefits and savings than interventions at any other time in their life span (DH, 2011)

The No Health Without Mental Health: Implementation Framework states “to improve people’s mental health and wellbeing, everyone needs to play their part, and that local leaders need to take action to ensure a range of services work together to promote wellbeing, to tackle the causes of mental ill health, and to act quickly and effectively when people seek the support they need to make their lives better” (DH, July 2012).

More recently ‘Closing the Gap: Priorities for essential change in mental health’ (DH, 2014) supports the continued improvements to prevent mental ill health and promote mental wellbeing, and many government departments have as a major policy priority identified joint working between agencies as essential in improving outcomes for people with mental health problems.

The Children Act (2004) proposed a national outcomes framework in order to ensure delivery of the five key outcomes for all children and young people. This remains the central policy driver for all work in this area. The Children Act places a duty upon all Local Authority partners to work together to ensure all children are able to: Stay Safe; Be Healthy; Enjoy and Achieve; Achieve Economic Wellbeing; and Make a Positive Contribution.

At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time.[i] One in ten new mothers experiences postnatal depression.[ii]

Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.[iii] Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed).[iv] Mental health problems in childhood predict the adoption of unhealthy lifestyles in adolescence.[v]

Mental health problems associated with physical illness can increase healthcare costs by more than 45% according to some international studies, which, if applied to NHS expenditure could mean that £8-13 billion of long-term physical health care costs are due to poor mental health.[vi] (Kings Fund, 2012)

Treatments for mental illness such as anti-psychotic medications have been shown to increase the risk of physical ill-health.[vii]

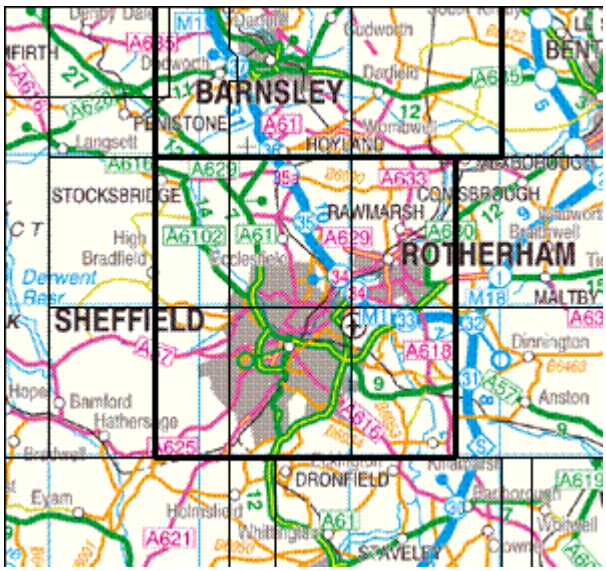
Barnsley has high levels of deprivation and although some improvements have been made in recent years, some individuals and communities continue to make high risk lifestyle choices that will impact on their future health outcomes and needs.

Barnsley still has higher than national average levels of smoking, alcohol intake and low levels of physical activity and healthy food choices, leading to: obesity, diabetes, heart disease, COPD, dementia, mental health problems and some cancers (JSNA 2013).

The proportion of Barnsley residents living with a limiting long term illness is 24.4%. This is significantly higher than England's average of 16.9%. This has a direct correlation to the increased health need in our population.

Our population continues to grow, and in particular, we have a growing elderly population. By 2021, 20% of Barnsley's population will be aged over 65 years; the elderly population is growing at a rate of 3% per year. Although life expectancy has improved, not all the added years to life are enjoyed in good health and we still have major issues in relation to disease prevalence and the requirement for care for people with complex health and social care needs.

People with long term conditions are twice to three times more likely to experience depression and estimates suggest that 20% of people with long term conditions have depression.



Barnsley's current population is approximately 233,700 (JSNA 2013), there are 54,711 young people living in Barnsley, of which 10,500 children under 16 living in poverty. 35.8% (19,564) of young people are living in areas that are amongst some of the most deprived in England.

Barnsley is the 47th most deprived Local Authority of the 326 English Districts.

The most recent data from the Office for National Statistics (ONS) indicate that in 2005 there were 125 deaths of 15 to 19 year olds from suicide or undetermined injury in England and Wales. This is a rate of 3.6 deaths per 100,000 population aged 15 to 19 years (ONS Vital Statistics and 2005 ONS Mid-Year Population Estimate). If applied to the population of Barnsley CAMHS Partnership this would equate to an estimate of 1 death from suicide or undetermined injury per year.

WHOLE SCHOOL/ COLLEGE APPROACH – CHILYPEP'S MODEL

The pilot focused on three main areas of work:

1. Mental Health awareness raising tutorials

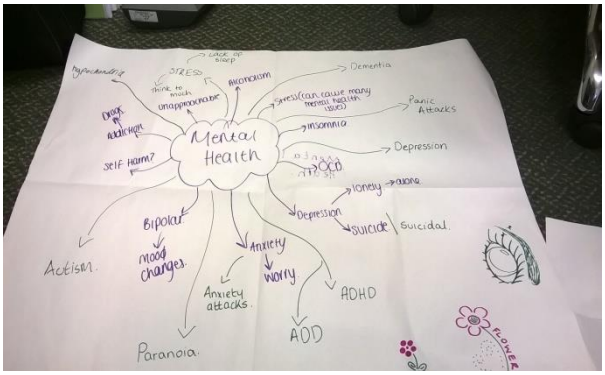
Initially a consultation was carried out with young people from the college during fresher's week, and with STAMP, a well-established mental health participation group based in Sheffield, around what should be included in educational tutorial sessions. From this sessions were developed and piloted within tutorials across college sites and further consultation was carried out with young people about specific issues they would like more tutorials or workshops on. As we developed our Emotional Wellbeing Champions (EWB) Programme, young people were trained to co-facilitate tutorials, which were delivered in line with what these consultations in college told us.

2. Development of peer support models

Chilypep recruited and trained a group of young people, who were passionate about mental health and emotional wellbeing, as 'Emotional Wellbeing Champions' within the college. The EWB Champions went on to co-deliver tutorials, develop and run anti-stigma projects within the college, and get involved in mental health awareness work outside of the College. In the new term they hope to develop one-to-one peer support networks across the college, putting their peer support training into action.

3. Staff training and development

Young people told us that often they feel unable to talk to tutors and other professionals about their mental health, with tutors telling us they wanted more training and development to enable them to better recognise, and respond to, the emotional wellbeing needs of their students. Frontline college staff were therefore offered mental health development workshops, and access to 'Youth Mental Health First Aid' to build their own skills and confidence to support students around mental health.



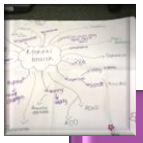
A WHOLE SCHOOL / COLLEGE APPROACH TO WELLBEING – THE PILOT MODEL

Education & Awareness

- Consultation - understanding student needs & wants
- Development & delivery of tutorial offer across sites
- Engagement of students in anti-stigma campaigns
- Evaluation

Peer Support

- Consultation - working with young people to define the offer
- EWB focused peer support
- Peer-led EWB events
- EWB training & support for peers
- Evaluation



Training & Development

- Consulation - understanding staff training & development needs
- Development & delivery of mental health awareness workshops
- Youth Mental Health First Aid Training
- Evaluation

1. EDUCATION & AWARENESS

Throughout the pilot, Chilypep aimed to **increase awareness and understanding** of mental health and emotional wellbeing amongst young people across college sites. We wanted to **get people talking** about their own wellbeing, raising awareness of mental health, and **reducing the stigma** that so often goes with it. School and college is where young people often spend the majority of their time, yet with mental health education still not embedded within the national curriculum, young people have told us that they don't often get to explore mental health whilst in education.

Giving young people the **space and time** to explore their own emotional wellbeing in a **safe and supportive environment** is vital if we are to create a culture of wellbeing within schools and colleges.

INVOLVING YOUNG PEOPLE FROM THE START

Chilypep believes that to empower children and young people is to involve them at all stages of planning, development, delivery and evaluation. We therefore worked with young People from our existing group STAMP who helped us to develop questionnaires and consultation methods to carry out with students from the college and to develop the initial sessions to deliver to them. Further consultation with students from the college highlighted the areas they wanted the tutorials to cover. These included:

- Mental health awareness
- Stress management
- Exploring and challenging stigma
- Self-harm awareness
- Self-help and resilience building

Students helped Chilypep to develop interactive session plans, to actively engage young people in the educational offer.
A typical tutorial session would include:

- Icebreaker & Introductions
- Group agreement
- Celebrity myth busting quiz
- 'Stand Up Kid' DVD
- Mental Health vs Physical Health word blast

- Stress Management
- Session evaluation

Top Tip: Feedback from young people has shown us that they engage well in these sessions because they are interactive and engaging as well as covering some serious content. Why not mix it up a bit and use interactive methods to deliver some of the 'heavier' stuff! We worked with young people to develop a 'play your cards right' game to deliver statistics so young people engage better, and use balloons to engage young people in thinking about what causes them stress; at the end of the session they can then burst the balloon once they've learnt some stress management tips!

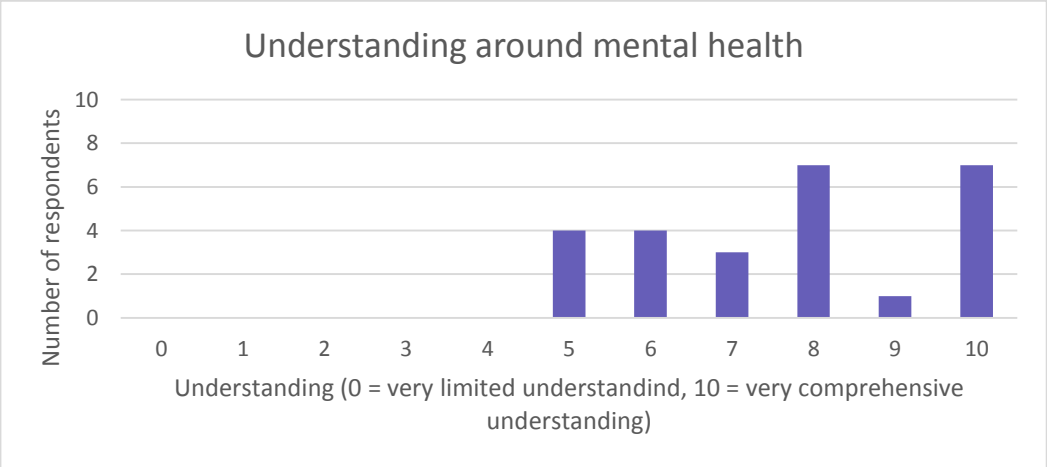
Useful links to resources can be found in the Appendix of this report if you are looking at facilitating emotional wellbeing sessions with young people!

PEER RESEARCH

Chilypep regularly involves young people in research and consultation to inform our work, and organisational priorities. As the Barnsley project began we therefore worked with young people from STAMP to develop an online survey for Barnsley college students to inform the planning and development of the pilot. In particular we wanted to gain an understanding of young people's knowledge and understanding around mental health, the support networks around them, and their knowledge of 'where to go' if they needed support, both within college and external to the college environment. In total 26 young people completed the questionnaire. Here are some of the results.

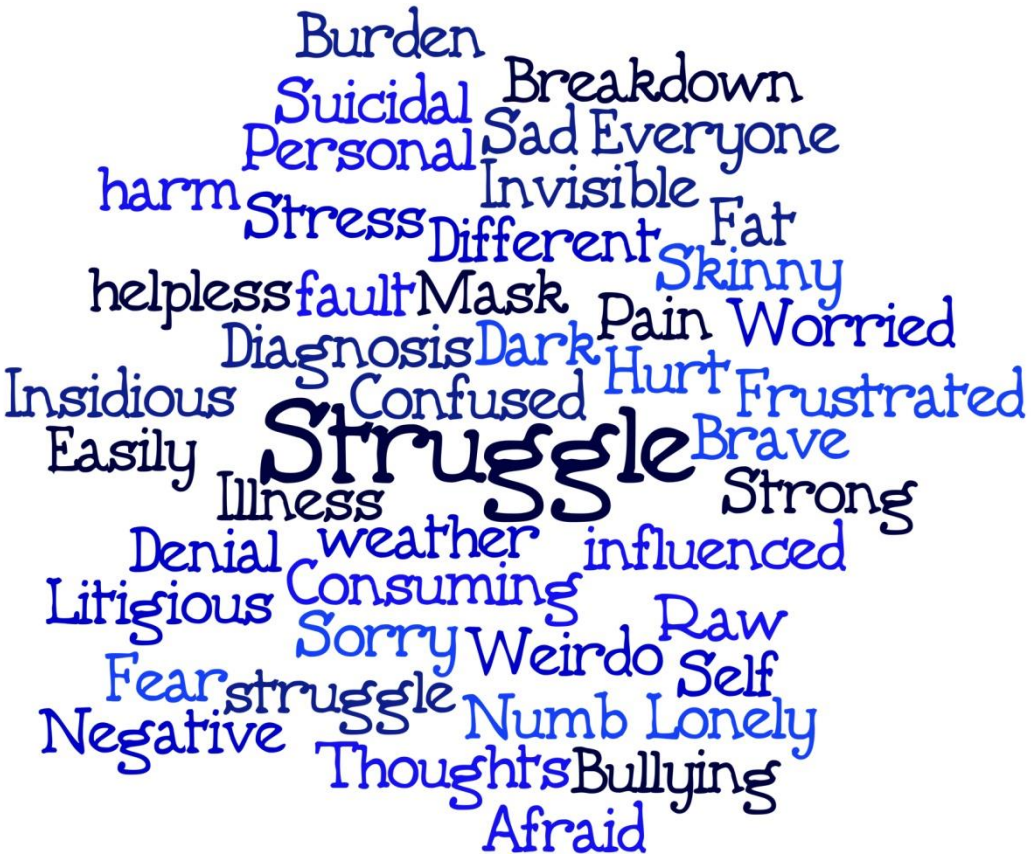
UNDERSTANDING AROUND MENTAL HEALTH

We asked young people to what extent they felt they had a comprehensive understanding of mental health. 100% of respondents indicated at least an average understanding around mental health, with 58% of respondents indicating a very comprehensive understanding around mental health.



Within tutorials however we often found that when exploring mental health with students they soon realised that their understanding of mental health was less comprehensive than they first thought, with students finding it difficult to define what ‘mental health’ meant. Furthermore we found that the term ‘mental health’ was often perceived in a negative light, with words such as ‘breakdown’, ‘lonely’, and ‘struggle’ coming to the forefront of people’s minds.

Words young people commonly associated with mental health included…

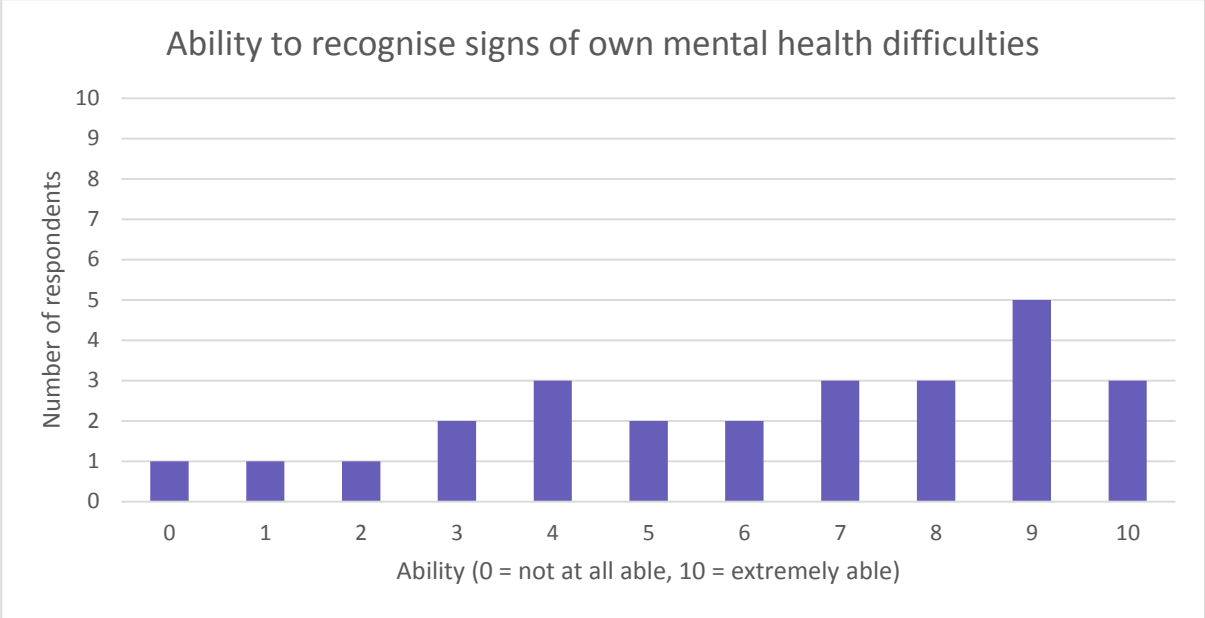


Following tutorial evaluations young people often quoted changes in their perceptions of mental health, such as *“I’ve learnt that mental health is something everyone has, it can be good or bad just like our physical health”.*

This would seem to indicate a change in perception around mental health, and a reduction in stigma following young people’s involvement in college tutorials. This highlights the need for young people to have the opportunity to explore mental health within college environments if we are to increase young people’s understanding around mental health and wellbeing, and reduce the stigma that can accompany the term ‘mental health’.

RECOGNITION OF MENTAL HEALTH DIFFICULTIES

From initial consultations with STAMP, we learnt that not being able to recognise signs of mental health difficulties in oneself had prevented young people from getting timely access to support. We therefore asked students how able they felt they were to recognise signs of mental health difficulties within themselves. The responses were varied, indicating that whilst the majority of young people completing the questionnaire felt they had a good understanding of mental health, they were less confident in recognising mental ill health within themselves.



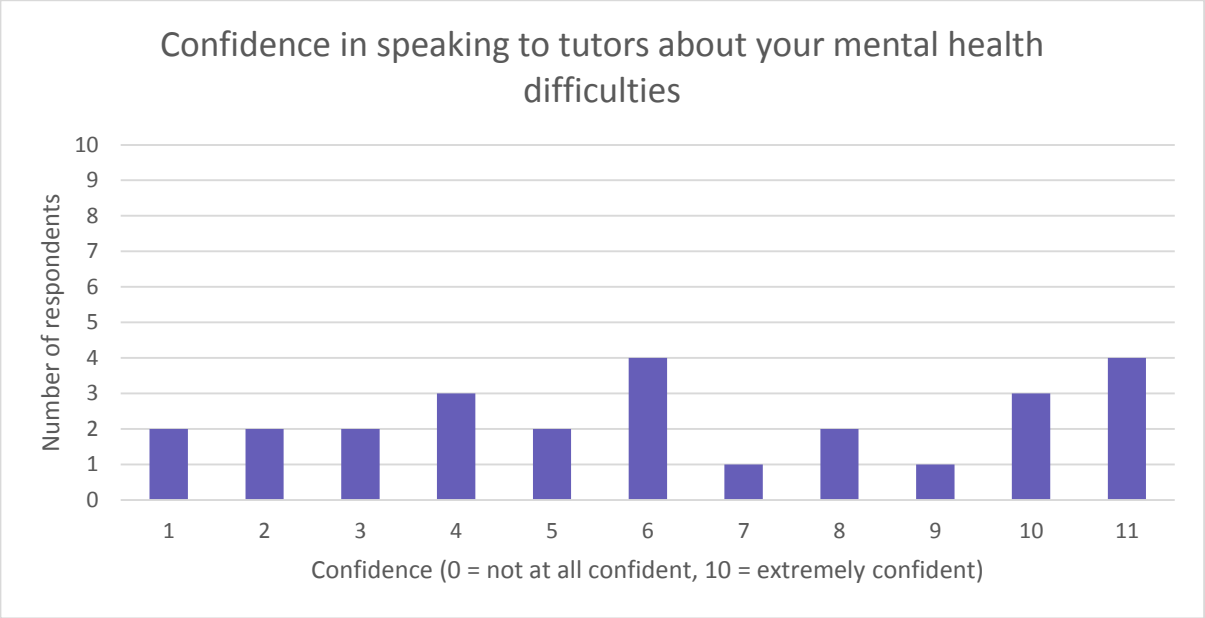
Recommendation: **All** students need to be taught about the signs and symptoms of mental ill health to enable them to seek help early on. Building the emotional intelligence of young people at an early age could also help young people to develop their own coping strategies, preventing them from becoming unwell when they notice their own wellbeing slipping.

CONFIDENCE SPEAKING TO TUTORS ABOUT MENTAL HEALTH

Previous research undertaken by Chilypep has revealed the importance of relationships within mental health support, and college environments. Whilst some young people will feel comfortable approaching a tutor about personal issues relating to their wellbeing, others have told us that they would not feel comfortable talking to a tutor, and would prefer to speak to a friend, or even someone completely removed from the situation.

We therefore asked students how confident they would be to speak to a tutor about their mental health. Again the responses were varied with each option being indicated at least once. The greatest percentages of respondents (15%) were either: neither confident nor unconfident in talking to their tutors about their mental health; or were

very confident in talking to tutors. 39% of respondents had a less than average confidence in talking to their tutors about their mental health. 42% of respondents had a greater than average confidence in talking to their tutors about their mental health.



Recommendation: There are many reasons why students may not feel confident in speaking to their tutors. From previous research Chilypep has found that this is often down to the relationship built and the confidence of the tutor themselves to engage in conversation around mental health with students. It is therefore recommended that tutors undergo training to recognise signs and symptoms around mental health and increase confidence in speaking with students.

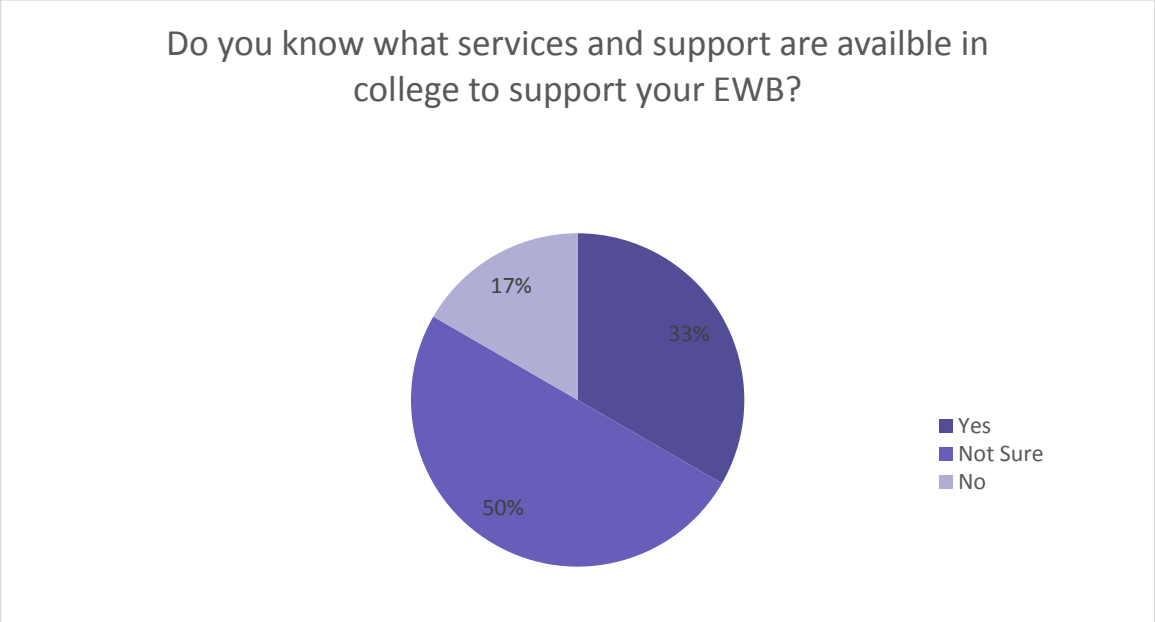
Some students did tell us that they would prefer to talk to someone outside of college (often so as to retain anonymity) or to a peer. It is therefore recommended that more visible information about other services and signposting information is available throughout the college, and work to continue and grow peer support networks within the college environment is undertaken.

KNOWLEDGE OF SERVICES AND SUPPORT AVAILABLE IN COLLEGE

Barnsley College has a range of services and support in place within the College to support the health and wellbeing of students. However half of respondents were unsure what support is available in college to support their emotional wellbeing. 33% of the respondents were aware of what mental health services/support is available in college, whilst 17% of the respondents indicated that they were completely unaware.

Those who said they knew where to go in college for support highlighted the following areas of support within college:

- The health and wellbeing centre
- Talking to a counsellor
- Personal tutors

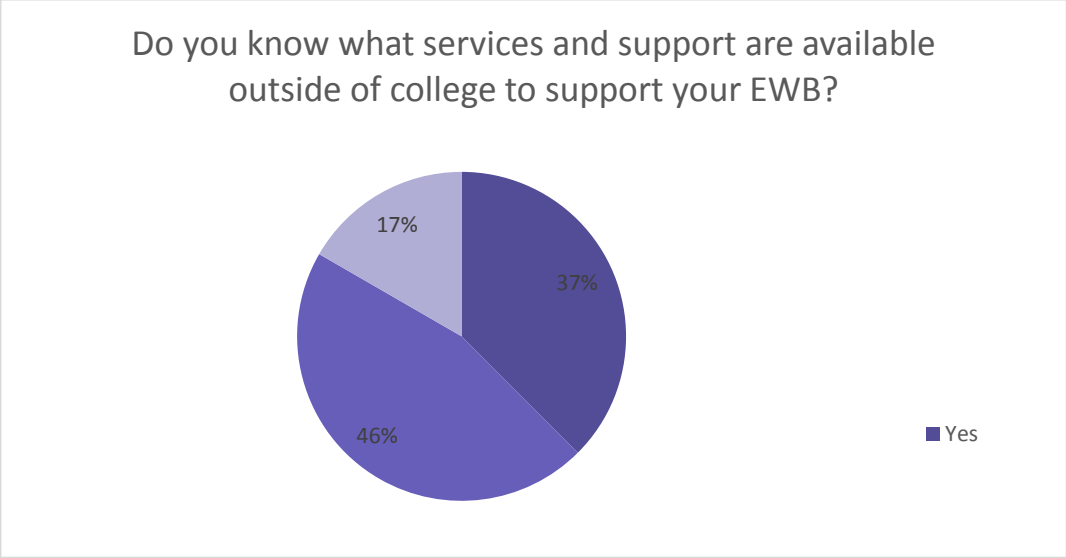


Recommendation: Whilst there are a number of services available to students in college to support their mental health, these are unknown to many students. It is therefore recommended that available services are promoted more widely across the college. The College could utilise the EWB Champions to support this process.

KNOWING WHERE TO GO…

The world of mental health support is often one that is very complex for young people to navigate, with many young people telling us that they would not really know where to go to for support. We therefore asked students if they knew what services were in place that they could access outside of the college environment.

Over half of the respondents (63%) were either unsure (46%) or totally unaware (17%) of what support and serves were available to them outside of college. Respondents were however more aware of mental health and wellbeing services and support available to them outside of college (37%) than services and support provided to them within college (33%).



The majority of places quoted were those providing formal mental health support, such as GP, mental health services, or helplines, with some young people saying they would go to friends and family for support. Interestingly, although young people seemed to know of some mental health support services, no specific local services were quoted. This may indicate the need for more signposting awareness amongst students as to what is 'out there' and how they can access it.

Services young people identified were:

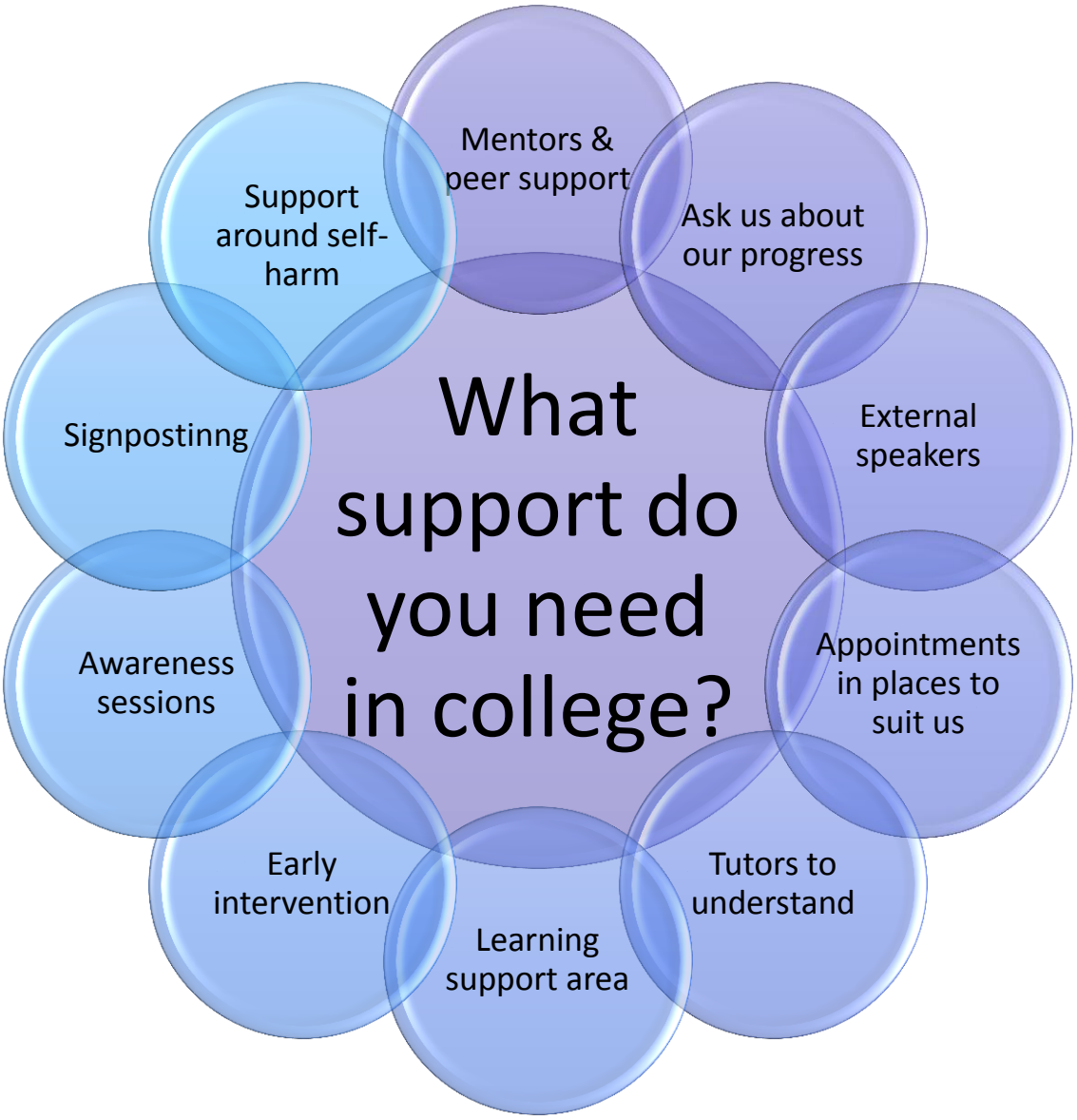
- Your GP and counselling sessions
- Counselling, friends and family
- CAMHS, your GP, doctors
- You can talk to your doctor and counsellor
- Mental health phone lines, support worker
- Suicide hotline, friends

Recommendation: Future work with could include working with the Emotional Wellbeing Champions to carry out a mapping of support and services in the local area. They could then develop a 'where to go' information leaflet or online forum that students could access to find help and support. (You can find out more about online support and signposting in the appendix resources area!)

WHAT SUPPORT DO YOUNG PEOPLE WANT?

Chilypep used time within tutorials to further unpick what support young people would like to see in the college environment to better support their emotional wellbeing.

Key recommendations from young people we spoke to included:



Recommendation: It is recommended that the College and Barnsley CCG take on board young people's recommendations in order to improve the emotional wellbeing support students receive within the college.

TOP TIPS TO POSITIVE MENTAL HEALTH

We asked young people during tutorials what things they could do to support their own mental health. They said…

- De-stress time
- Do fun things
- Films, TV, Video games
- Positive quotes & thoughts
- Don't hold back your opinions
- Understanding from tutors
- Get professional help if you think you may need it
- Have a diagnosis
- Listening to music
- Be open, honest and happy
- Pub
- Mates get on and understand me
- Work with others
- Peer support

TOP TIP: In order to sustain positive mental health it is really important to develop a sense of what helps you to help yourself. Young people are experts in own lives and therefore in maintaining their own wellbeing! Why not ask young people what they need and support young people to identify the things that help them stay well? Visit www.actionforhappiness.org for some great tools that can help you with this.

LET'S TALK ABOUT MENTAL HEALTH

Over the course of the pilot project Chilypep delivered a total of 50 tutorials, engaging 265 young people across college sites.

Within the short space of an hour Chilypep often noticed young people's perceptions around mental health shift quite dramatically, with often quite stigmatizing language being used at the beginning of a given session, and by the end young people expressing an interest in becoming involved in the pilot project, or disclosing around their own mental health.

Over the course of the tutorials Chilypep received 11 disclosures from young people; disclosures were commonly around self-harm, depression, anxiety and difficulties sleeping. Of those young people disclosing mental health problems, approximately 5 went on to receive support through the college services, such as IAPT and the wellbeing centre. Others said they did not want to access anything within the college environment and so were signposted to alternative sources of support.

In addition to disclosures during, or following, tutorials, young people were signposted to the project's facebook page. We found that giving young people access to an online forum led to further disclosures, with young people contacting Chilypep's Emotional Wellbeing Worker directly via facebook to seek further support. In one case this led to a young person speaking to the worker about how he did not know where to go to for support. He was not registered with a GP and did not know of any local services.

Chilypep's Emotional Wellbeing Worker encouraged them to register with a GP, which they did, and they then went on to get some emotional wellbeing support. This highlights the need for alternative forms of communication, such as online forums, where young people often feel more comfortable to seek additional support.

The fact that young people felt able to disclose their own concerns around their mental health following brief interventions, demonstrates how actively engaging young people in informal mental health education can not only open up discussion around mental health, but can lead to young people taking the step towards accessing support.

Recommendation: Both staff and young people highlighted the value of the tutorial offer. It is therefore recommended that this continue across college sites and it becomes embedded within the college culture.

2. PEER SUPPORT – BARNSLEY EWB CHAMPIONS

Learning from the Right Here project highlighted the importance of peer support models in improving the emotional wellbeing of young people. An integral element of the Whole School/ College Approach was therefore the development of the Barnsley 'Emotional Wellbeing Champions' Programme.

EMOTIONAL WELLBEING CHAMPIONS

Chilypep gathered previous learning around engaging 14-25 year-olds in discussing mental health and well-being, based on the idea that everyone has mental health and should be supported to look after their mental health on a daily basis to prevent deeper issues becoming entrenched. From this the idea of EWB Champions was developed to offer young people in schools, colleges and communities the opportunity to develop their skills, knowledge and confidence to speak out around mental health issues, offering peer support and guidance to their peers.

As an 'EWB Champion' young people received training such as consultation and research skills to enable them to understand the issues young people face; facilitation training to enable them to deliver peer led healthy conversations to other young people; and influencing and campaigning training to enable them to make a difference to mental health at a strategic level.

Chilypep actively promote Peer Mentoring approaches because we have found that:

- Young people tend to engage better with other young people than with older adults
- Our EWB Champions use engaging tools and approaches designed by them to ensure they capture the interest of young people (these include a board game, exercise and smoothie-making to discuss mental health and well-being).
- The stigma around mental health problems means that this can be a difficult subject to discuss unless you feel shared interests and experiences with the facilitator as you do with a peer-facilitator.
- EWB Champions get access to training and support from Chilypep increasing their confidence, resilience and skill base.
- The college or school becomes a healthier place for students to be, improving the college environment for both staff and young people, whilst supporting the education and attainment of pupils.

BARNSLEY COLLEGE EMOTIONAL WELL BEING CHAMPIONS

Initially ten young people were recruited to become EWB champions, with eight going on to complete the peer mentoring training programme, and six remaining actively engaged at the end of the project.

DEVELOPING A PEER MENTOR TRAINING PACK

For young people to be able to meaningfully engage within the EWB Champs project it was necessary to develop a comprehensive Peer Mentoring training package. Chilypep worked with the EWB Champions to ask them what their training needs were and adapted training we had delivered in the past and adapted these to match the skills the EWB Champions were wanting to develop.

The ongoing training programme Chilypep delivered to the EWB Champs included:

- Team building – Icebreakers, energizers, team work activities
- Setting project/ role expectations - Hopes, fear, expectations
- Communication skills – speaking, listening, mirroring
- Leadership skills
- Facilitation skills
- Equal opportunities/ assumptions/ perceptions
- Myth busting
- Assertiveness
- Child protection, safeguarding, boundaries, confidentiality

In addition to this we also ran sessions with young people to discover what the issues are that young people may be facing. This included looking at a diverse range of topics such as sexual health, relationships, social problems, and of course an in-depth exploration of mental health and mental health problems that young people might face. For more information about our training visit www.chilypep.org.uk .

Stamping Out Stigma!

The Emotional Wellbeing Champions ran a week long anti-stigma campaign around college to showcase that mental health is something we all have and encourage others to speak about mental health. Over the course of the week we ran tutorials with the EWB Champs, and took over part of the college putting up a 'Wellbeing Tree' where students were encouraged to write down what was going on for them, and how they could support themselves to feel good.

Peer-peer facilitation

Once trained the EWB champions felt more confident to support Chilypep's Emotional Wellbeing Worker in the delivery of college tutorials. As part of the tutorial Chilypep plays 'Stand Up Kid', a time to change film where a young person, having been off school with depression, stands up on a chair in the middle of the classroom to tell his story. Following the showing of this film during one session a member of the EWB Champs group, who was co-facilitating, took the impromptu move to 'stand up' and tell his own story to the class. This demonstrates how one young person through such a project can themselves become empowered to share their story with their peers in order to raise more awareness and reduce stigma around mental health.

Going one step further…

The EWB Champions did not only take part in the college project but were keen to get involved in other aspects of Chilypep's work. Shortly after starting the programme, we invited the Champions to a regional 'Voice and Influence' residential organised by British Youth Council.

The majority of the young people were youth council, or youth parliament representatives and this was at first quite intimidating to the young people who attended. However on the second day some of the Champions stood up and told their own stories and shared their passion for campaigning around mental health for young people.

In addition to the residential, members of the EWB champions, supported Chilypep in the development and filming of two short films; one in relation to young carers, and the other in relation to mental health. The films can be found here:

Young Carers Need Care Too: https://www.youtube.com/watch?v=_5pfgvFGSi4

Move Forward with Mental Health: https://www.youtube.com/watch?v=k5o5ei_FxFA

CASE STUDIES

Drew, Age 17.

Drew, aged 17, took part in the EWB Champions Programme. In preparation for a visit from Barnsley CCG he prepared his own story of why it was important to him to be involved in the project:

"Hello, my name is Drew Brewster. I am 17 years old, unfortunately I am not able to make it today to read this myself, let me paint a picture, medium height, brown eyes and hair, and very good lucking no, just a little joke. This is my story.

My childhood was bad, my father was in and out of prison for many things like breaking and entering, robbery, drugs etc my father also used to beat me, this is where it all started I felt victimised and singled out, as I have a brother and 3 sisters, yet I was the only one who got abused, I believe this is the root of my illness, I love my mother, as most people do, but it's different, my mother had cancer at the age of 12-18 years old, she is a very strong person, and pulled through, kicked cancer right where it hurts, when I was young, she was my safe haven, and she used to protect me from my dad whenever she could, when my father left, I became 'the man of the house' and helped my mum raise my brother and sisters. I didn't attend school, as my situation at home was more important. I fell behind massively, and got bullied, this only motivated me at year 9 to get my head down.

I'm now studying A-level chemistry, biology, physics and math. When I was 8 my mother developed a heart condition, severe enough that she had to have a heart transplant, this was a very hard time for me, I was 10, when she went for her procedure, I was without my mother for 4 month, no contact at all, this was horrible, imagine someone smashing there hand through your chest and ripping out your heart, and keeping it in a box for 4 month, when I did get to see my mother for the first time, she couldn't move, nor speak, this was weird more than anything, because my mother could never sit still, you could almost see the energy in her eyes, this made this especially funny when a few week later she kicked my sister for making a funny joke about me, it was so unexpected, anyway my mother made a full recovery, against all the odds, she is like a steel wall, unbreakable, well that's until the 9th of October 2010 when she passed away due to a blood clot in her leg. After everything, she died over a bit of thick blood.

This was the lowest point of my 17 years of life, I hit rock bottom, I became depressed, a day after my mother's death, on the 10th of October 2010, I self-harmed for the first time, this was also my 12th birthday. My self-harming got bad, really bad. I put myself in hospital on two occasions with severe lacerations to my legs. I got called a freak, emo, attention seeker. My auntie and uncle, who I moved it with after a short stay in care did all they could to support me, but I was driving them away, making my auntie Ill with stress. I attended camhs, school nurse, but nothing worked, I am now on antidepressants, self-harming is still an issue but not to the extent it used to be, a year ago I managed to stay cut free for about 3 month, but I relapsed, and now I haven't self-harmed in over 3-4 month, and still going strong, with the help of all the amazing people here at chilypep, as one of the newest members, I feel like I am part of a family, a healthy atmosphere, and I know chilypep, us, we, are going to help many more people with mental illness. Thank you. For your time and support you have invested in chilypep."

Grace, Age 17

Grace was one of the young people from Barnsley College to take part in the EWB Champs programme. She has since gone on to engage in a number of other projects with Chilypep, including co-facilitating the peer mentoring training to a group of NCS (National Citizen Service) young people over August 2015, and, as the pilot drew to an end, becoming a 'Peer Befriender' to young people with mental ill health in North Sheffield.

"When I first started the EWB program at Barnsley College I wanted to achieve a better understanding myself of mental health and how to talk about it effectively with people who have little prior understanding of mental health currently. I believe that I have successfully achieved this over my time with the group. I also wanted to improve the steps the college takes when it comes to a student's mental health. Which I believe we have/ will due to our group implementing out peer mentor scheme. Throughout the program I have developed many skills such as being able to sympathise and empathise much better with situations I hadn't before. I have also built my confidence levels so that I can challenge stigma, making people stop and listen effectively. In my opinion this

program must continue as in the short space of time it hasn't just helped one person yet it has set out to effectively improve mental health standards for the future at Barnsley and all the people that have taken part in the emotional wellbeing group will continue to make an impact throughout the rest of our lives."

Grace, Emotional Wellbeing Champion, age 17.

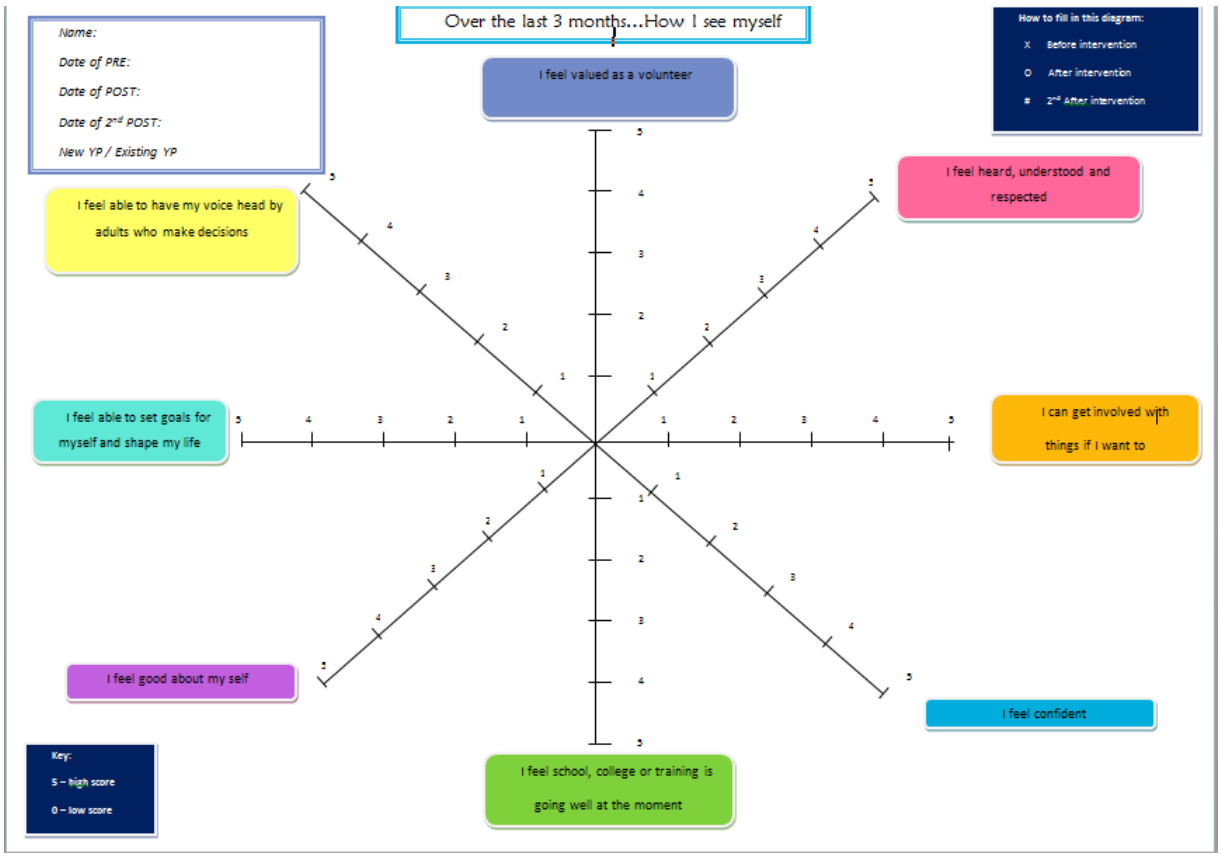
BARNSLEY COLLEGE EWB CHAMPIONS – OUTCOMES FOR YOUNG PEOPLE

Young people engaging in the programme highlighted how their involvement became a means not only to improving the emotional wellbeing of other students, but in turn improved their own mental health:

"My confidence has grown a lot and my mental health has improved."

"Being involved in 'EWB Champions' has helped my confidence grow and made me feel like I can talk to more people."

Chilypep has developed a measurement tool, a participation Spidergram that can record participation levels in children and young people and how this impacts on mental health and emotional wellbeing. The participation Spidergram was used throughout the project to measure how involvement and participation within the EWB Champions programme impacted on our EWB Champs' Wellbeing and Mental Health. An example of the Spidergram can be seen below:



The purpose of the tool is to demonstrate how participation in activities such as this programme can impact on and improve a child or young person's mental health and wellbeing. The tool was used to record young peoples' feelings and behaviours, by asking where they believe they were at the start and end of the process, with interim data also recorded.

The Participation Spidergram has been modelled on the Outcomes Star (a tool for measuring change when working with people www.outcomesstar.org.uk), with the Mental Wellbeing Checklist (National Mental Health Development Unit) http://www.mhfe.org.uk/sites/default/files/nmhdu-briefingmental-health-strategy.pdf provided the framework for developing the Spidergram. The checklist was developed as part of the MWIA toolkit for well-being and identifies the major influences on mental wellbeing. The checklist is evidence based and provides information on what protects individual and community mental wellbeing, what the wider determinants of mental well-being are and which populations face the greatest inequalities in mental well-being.

For this project measures were selected across the areas the Checklist identifies as influential and which relate to the work of Chilypep, and a series of questions were generated to translate these into tangible questions, which could easily be understood by young people of all ages, abilities and back grounds.

For the Emotional Wellbeing Champions programme the chosen measures were:

Measures	**Questions**
Belief in own capabilities and self-determination *(e.g. setting & pursuit of goals, ability to shape own circumstances)*	• *I can achieve things*
Opportunities to influence decisions *(e.g. at home, school, work, with services or decision makers, or in the community)*	• *I think my ideas and opinions can make a difference* • *I feel I have a role in taking action in my community*
Opportunities for expressing views and being heard *(e.g. in groups, public meetings).*	• *I feel listened to* • *I am confident to express my voice and opinions.*
Emotional Wellbeing *(e.g. self-esteem, self-worth, confidence, hopefulness, optimism, life satisfaction, enjoyment and having fun).*	• *I feel good about myself*
Having a valued role *(e.g. group member, volunteers, governor, carer)*	• *I feel valued as a volunteer/participant*
Feeling involved *(e.g. in the family, group, school, community or at work)*	• *I enjoy being part of a team*

We asked the EWB Champions to complete the Spidergram when they became involved in the project, and then at regular intervals throughout. In total 9 young people completed the Spidergram, with 6 completing these on a regular basis. We have therefore calculated the results of the Spidergram based on the six young people who remained engaged throughout the entire process.

100% of young people reported increased sense in their beliefs that they could achieve things.

5 out of 6 young people reported an increase in thinking that their ideas and opinions could make a difference, with one young person remaining the same.

5 out of 6 young people reported an increased feeling of having a role to play in taking action in their community, with one young person remaining the same.

100% of young people showed an increase in feeling like they were listened to.

100% felt more confident to express their voice and opinions as a result of their involvement.

100% showed an increase in their sense of wellbeing quoting that they felt good about themselves more often as the project went on.

100% showed an increase in feeling valued as a volunteer/ participant within the project.

100% showed an increase in their levels of enjoyment of being part of a team.

EWB CHAMPIONS – THE BENEFITS ON THE INDIVIDUAL

"My confidence has grown a lot and my mental health has improved."

"It has helped widen my understanding of mental health."

"I feel as though I have matured loads! – I now know how to be a representative to my best ability."

"Being involved in 'EWB Champions' has helped my confidence grow and made me feel like I can talk to more people."

IMPACT OF PARTICIPATING IN THE EWB CHAMPS PROGRAMME

"This project has helped me to manage my stress and anxiety, allowing me to share my experiences with others to help them."

"Before I started 'EWB Champions', I didn't feel like I could talk to anyone. Now I find that I have a number of people I can talk to and they can also talk to me."

"It has allowed me to know much more about mental health."

"I have recently started counselling and I am starting a behavioural management course, as well as seeing a dietician."

"My mental health has improved amazing, along with it helping me making steps to further improve and to effectively help friends with their mental health."

THE PROGRAMME HELPED OTHER YOUNG PEOPLE TOO!

"People now feel freer to talk to other people and are more aware."

"Helped others to open up to us more, in a trusted environment."

"People know who they can turn to if awaiting counselling."

"People now know who to come to for help and support when no-one else is available."

PERSONAL AND PROFESSIONAL DEVELOPMENT OF YOUNG PEOPLE

Many noted career changes, or didn't know what to do before…

"I now want to work with young people."

"I would like to relieve my stress through working and helping animals."

"I hope to become a mental health nurse."

"I want to attend university to study a degree in 'Mental health nursing' at UCL."

PEER MENTORING TRAINING

"I understood the training, in the way it was delivered."

"Learnt loads – may need a refresher in a few months please?"

"It were aimed towards us and so wasn't just babble, it were good information, meaning my understanding has improved."

"Peer mentor training were great, we learnt lots of ways of helping people through hard times."

"Awesome."

"Extremely informative – I can't wait to be a 'Buddy'."

BUT, THERE IS ALWAYS ROOM FOR IMPROVEMENT!

"Sessions could have been more regular."

"Maybe starting tutorials slightly earlier – due to exam dates disrupting final tutorials."

"This group to start earlier."

"Sessions could last longer."

OVERALL FEEDBACK

"It's been amazingly fun and brilliant! I have made life-long friends, done things I wouldn't have imagined myself doing and my confidence has grown."

“It’s been an amazing experience, I have loved every minute of it and we learnt so much.”

“Amazing! I feel as if I have made so many memories and am ready to help others! Woo!”

“Amazing! Great memories, great friends! Made such an improvement in my mental health and made steps to improve it further.”

“My mental health has improved loads!”

“Keep it up! We want more!”

TOP TIPS TO RECRUITMENT

Staff at Chilypep are regularly asked how they go about recruiting young people to our projects and particularly how we ensure they remain engaged in the long term. This section of the report therefore sets out some of Chilypep's 'Top Tips' to recruiting and retaining volunteers.

VALUE BASED PROJECT DESIGN

Chilypep has a core set of values that we believe helps guide our work with young people:

1. We believe that to empower children and young people is to involve them in all stages of planning, development and making things happen and work well.

2. We believe that children and young people should decide what's important to them. Our job is to help them make choices and decide what they want to do about them.

3. We believe that the way we work with young people is just as important as the end results. This means making sure they are safe, protecting them if they are in danger, respecting them, treating them as equal partners, recognising and celebrating the differences between everyone, and helping them to be tolerant and supportive to each other.

4. We believe that all children and young people have the right to be involved in decisions that affect them and that for young people things are not equal or fair, so we need to make sure they are not left out.

THE WIPPY WAY

Chilypep ensure they work to the 'WIPPY principles' to ensure that young people have a positive experience working with us. The WIPPY principles are a set of principles that were developed by a former Sheffield networking group WIPPY (Working In Participation Projects with Children and Young People). Whilst this group no longer meets, the principles continue to be held in high regard, acting to outline how workers can carry out consultation or participation projects in a respectful way, so that children and young people have a positive experience.

Working through the WIPPY principles before you start a project will ensure that you have considered the things you need to make sure your project is meaningful, inclusive and rewarding for children and young people. It can also act as a tool for workers to be clear with what it is they are wanting to achieve.

There are 6 key areas to the WIPPY principles:

HONESTY

- Being honest with children and young people about what can and can't be done
- Identifying a clear purpose about what the process wants to find out and why
- Agreeing that any record keeping is a true reflection of children and young people's views and ensuring that permission is sought for use of their work

COMMUNICATION

- Using processes that are children and young people friendly, which respect different ages, understanding, abilities and styles
- Using children and young people's words whenever possible and avoiding the use of jargon
- Involving children and young people at all stages of the process, including planning and feedback in a manner that works for them

REALISM

- Giving only commitments that we can honour
- Ensuring sufficient resources and funding are identified to carry out the agreed work
- Committing sufficient time to ensure a process of high quality that is respectful to children and young people

INCLUSION

- Increasing access for a diverse range of children and young people, not merely the most visible
- Involving children and young people in all parts of the process appropriate to their age, skills, experience and abilities
- Developing appropriate strategies that work towards equal opportunities practice throughout the process

RESPECT

- Making sure children and young people's voices are heard and acted on; and they are told what has and has not changed as a result
- Working without prejudging the outcome or the contributions of the participants
- Offering support in order for children and young people to speak freely and power gaps to be bridged
- Providing a process that is a positive experience for children and young people

RECOGNITION

- Genuinely acknowledging the contribution from children and young people of the time and skills they contribute

- Acknowledgement that expenses may be incurred by the children and young people and that these are supported within the work resources
- Offering incentives and rewards appropriate to the children and young people we work with
- Providing appropriate access to accreditation opportunities.

Top Tip: Chilypep have some great planning tools that can help you put the WIPPY Principles into action – just contact us for more information!

WHAT DID WE DO DIFFERENTLY?

Chilypep always ensures that young people are at the centre of our work, and that our work in led by young people. This means building up a true partnership between young people and adults, and ensuring young people are involved from the start.

By involving young people in the planning, design and delivery of our projects we ensure that 'the offer' remains appealing to young people; that it meets the needs of young people and is delivered in a fun and engaging way. This means being on a level with young people, understanding what their needs are, and making sure young people are respected.

Chilypep recommends keeping in mind the 7 principles of youth work to make any project successful:

1. Young people choose to take part
2. Start with the young person's view of the world
3. Treat young people with respect – by listening to what young people say
4. Seek to develop young people's skills and attitudes rather than seeking to remedy 'problem behaviours'
5. Help young people develop stronger relationships and collective identities
6. Respect and value difference
7. Promote the voice of young people – all young people have a right for their voices to be heard

3. STAFF TRAINING & DEVELOPMENT

Staff training and development formed a core element of Chilypep's offer, recognising the vital role staff play in embedding a culture of wellbeing across school and college sites, and in supporting young people around their mental health and emotional wellbeing.

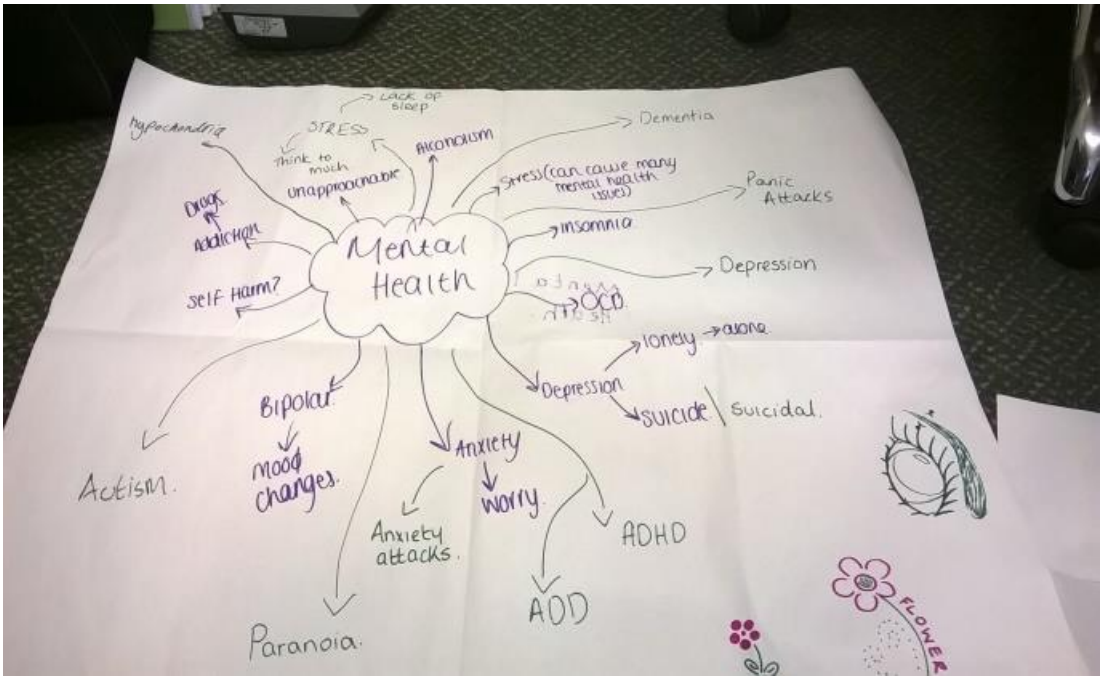
There were 3 main elements to staff training and development:

1. Continuous Personal and Professional Developlent of staff through attendance at tutorials, access to Chilypep's Emotional Wellbeing Worker onsite at College, and regular visits from Chilypep team to staff meetings and tutor learning sessions
2. Mental Health workshops offer to college staff
3. Access to 'Youth Mental Health First Aid' certificated training course

STAFF RESEARCH FINDINGS

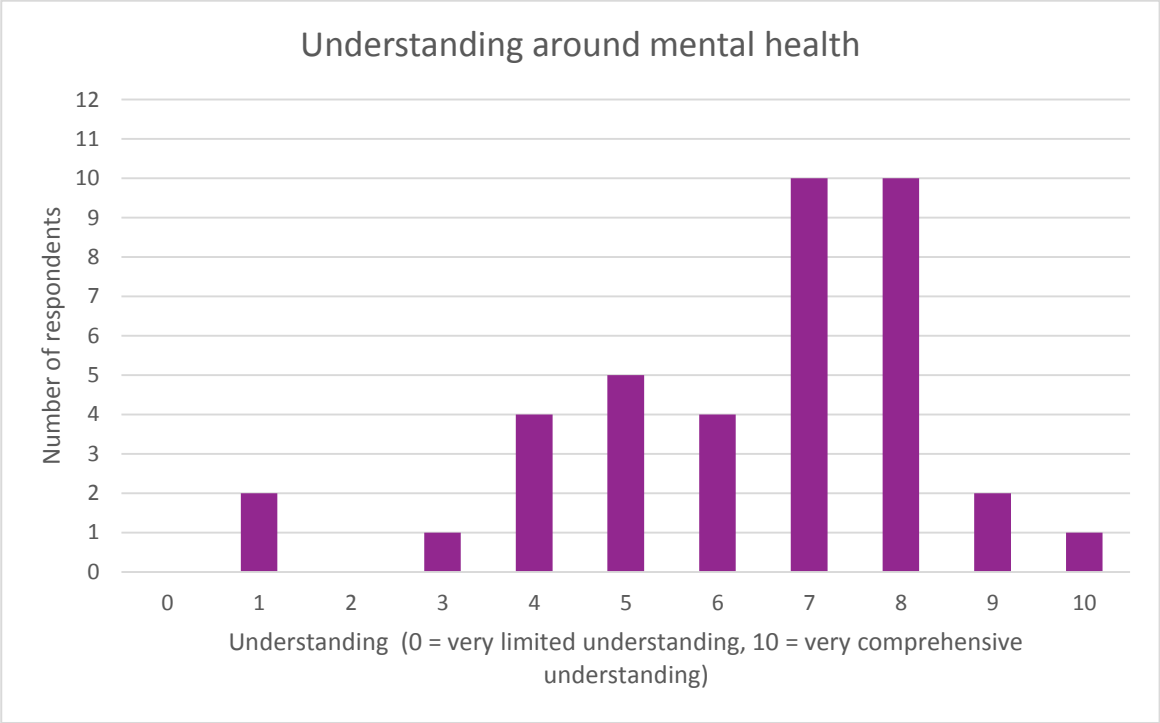
Chilypep aims to ensure that any project delivered is designed in conjunction with the needs and wants of those we are working with. Chilypep therefore carried out initial research into staff needs in relation to the pilot project. We did this initially by visiting team leader tutorials to tell them about the project, gage their understanding around the mental health and emotional wellbeing needs of students, and gain an insight into the training and development needs of staff themselves.

In addition to staff members completing paper based questionnaires during tutorials, 39 staff members across college sites completed an online survey monkey. The data gathered informed the training and development offer.



UNDERSTANDING AROUND MENTAL HEALTH

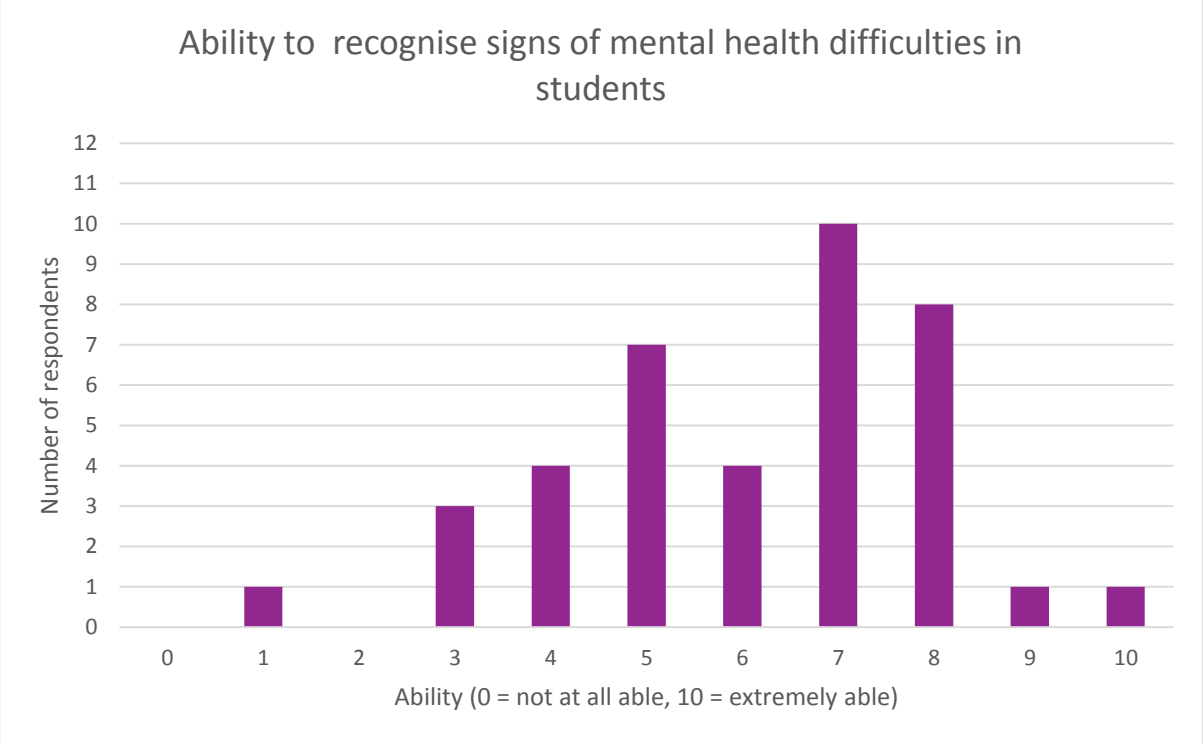
We asked staff about their understanding of mental health. The responses to this question varied, with at least one respondent indicating all but two of the options. 3 respondents (8%) indicated a limited understanding, and 13 respondents (33%) indicated an average understanding. The majority of respondents, 23 (59%) indicated a comprehensive or very comprehensive understanding around mental health.



Recommendation: Whilst the majority of staff indicated that they had a moderate to high understanding around mental health, there were also relatively high percentages of staff stating that they had a low to medium understanding. In initial tutorial consultations with staff many stated that whilst they felt they had a basic understanding around mental health, they did not always feel confident working with students around mental health and could benefit from further training.

It is recommended that there be an ongoing training offer to staff across college sites in relation to mental health and emotional wellbeing.

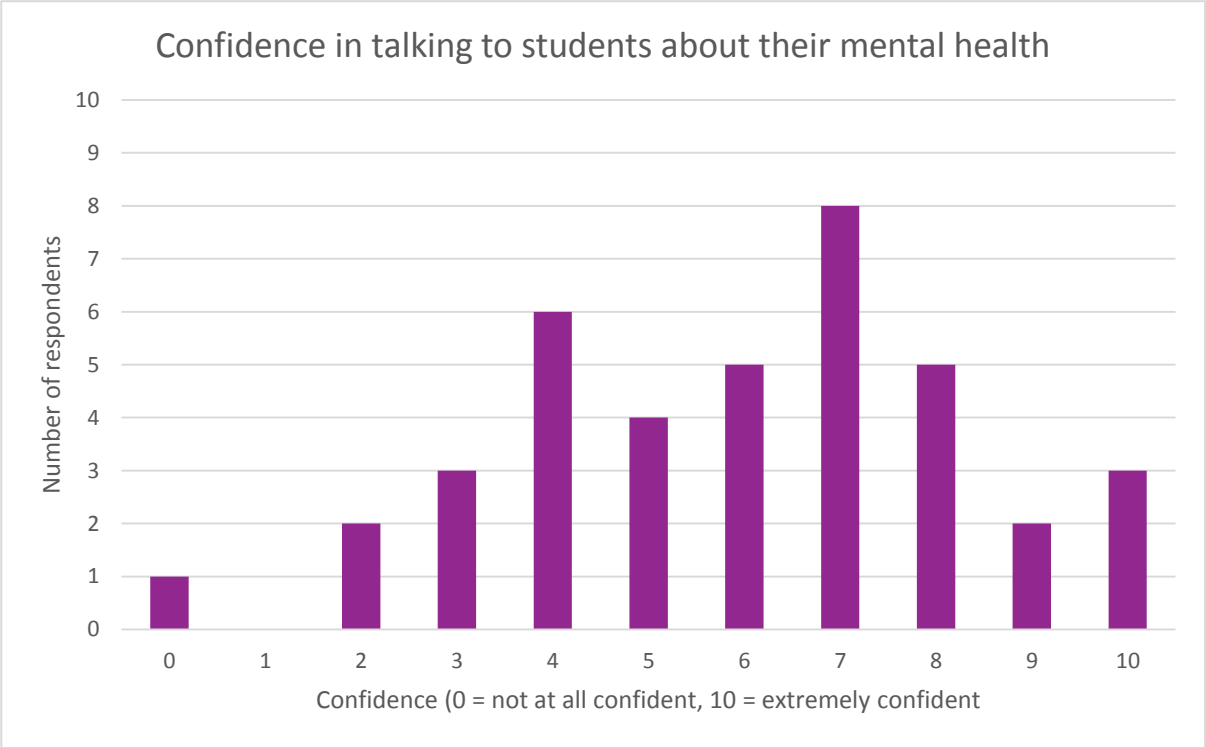
ABILITY TO RECOGNISE SIGNS OF MENTAL HEALTH DIFFICULTIES IN STUDENTS



The ability to recognise signs of mental health difficulties in students varied. 10% indicated they did not feel able to recognise signs of mental health difficulties in their students, 38% indicated they felt somewhat able to recognise signs of mental health difficulties in their students, and the majority of respondents, 20 (52%) indicted they felt able to recognise signs of mental health difficulties in their students. However, of these only 2 respondents (5%) indicated they felt extremely able to do so.

Recommendation: Students we have worked with in the past have told us how their stories may have been different if they had got help early on. Young people have told us they want to raise awareness about the issues affecting young people to the adults around them, so that they can recognise mental ill health in young people and offer support. It is recommended that the college offer more training and support to staff to enable them to feel more confident in recognising signs of mental health difficulties in students. Young people themselves could be involved in the design and delivery of such training!

CONFIDENCE TALKING TO STUDENTS ABOUT THEIR MENTAL HEALTH

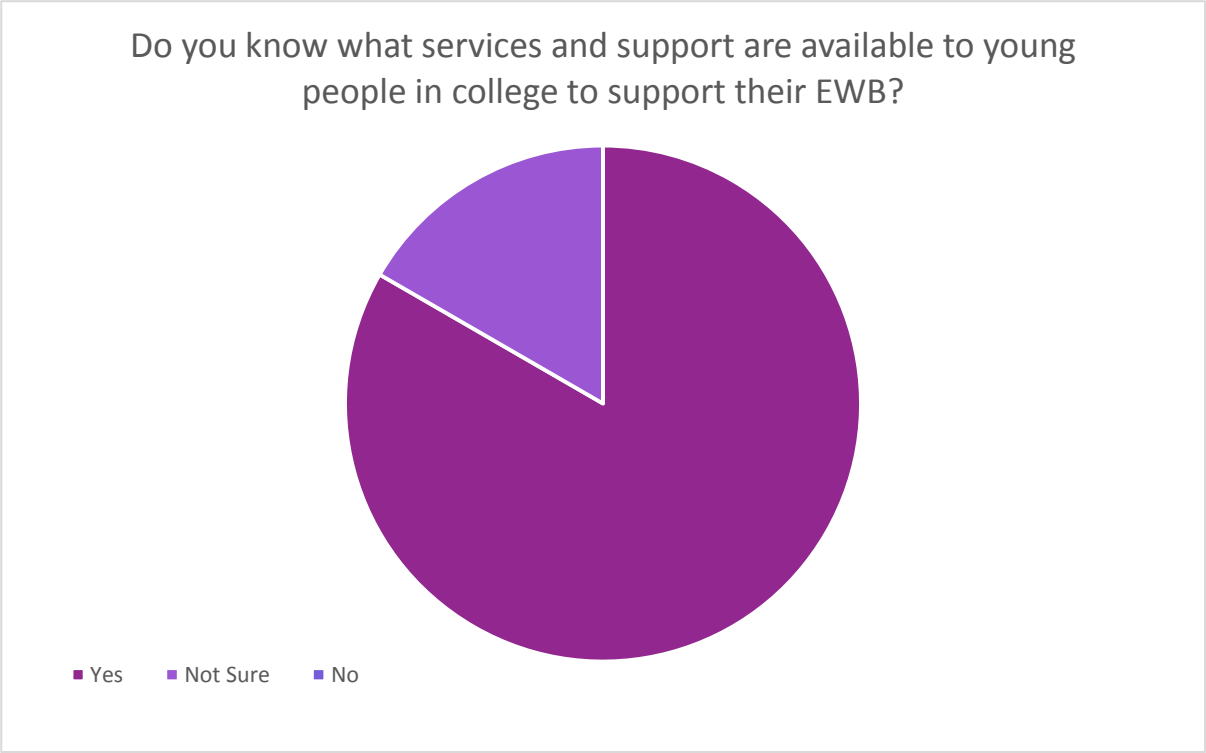


The confidence staff had on talking to students about their mental health again varied greatly. 6 respondents (15%) indicated they had little confidence in talking to their students about mental health, with 1 respondent (3%) indicating they had no confidence in doing so; 5 respondents (39%) indicated they were somewhat confident in talking to their students about mental health; 18 respondents (46%) indicated they were confident talking to their students about mental health, with 3 respondents (8%) indicating they were extremely confident.

These results are in line with previous research we have undertaken, that has highlighted a lack of confidence with teachers/ tutors and other adults talking to young people about their mental health. Reasons for this are varied, including a fear of making things worse, or safeguarding issues arising, as well as a general anxiety around having such conversations.

Recommendation: It is recommended that there be more CPD for staff at college sites around talking to young people about their mental health, as well as training around signposting for further support. The college may want to consider having mental health as a standing item on team meetings, and putting in place designated 'go to' staff acting as mental health champions within their teams.

KNOWLEDGE OF SERVICES AND SUPPORT WITHIN COLLEGE

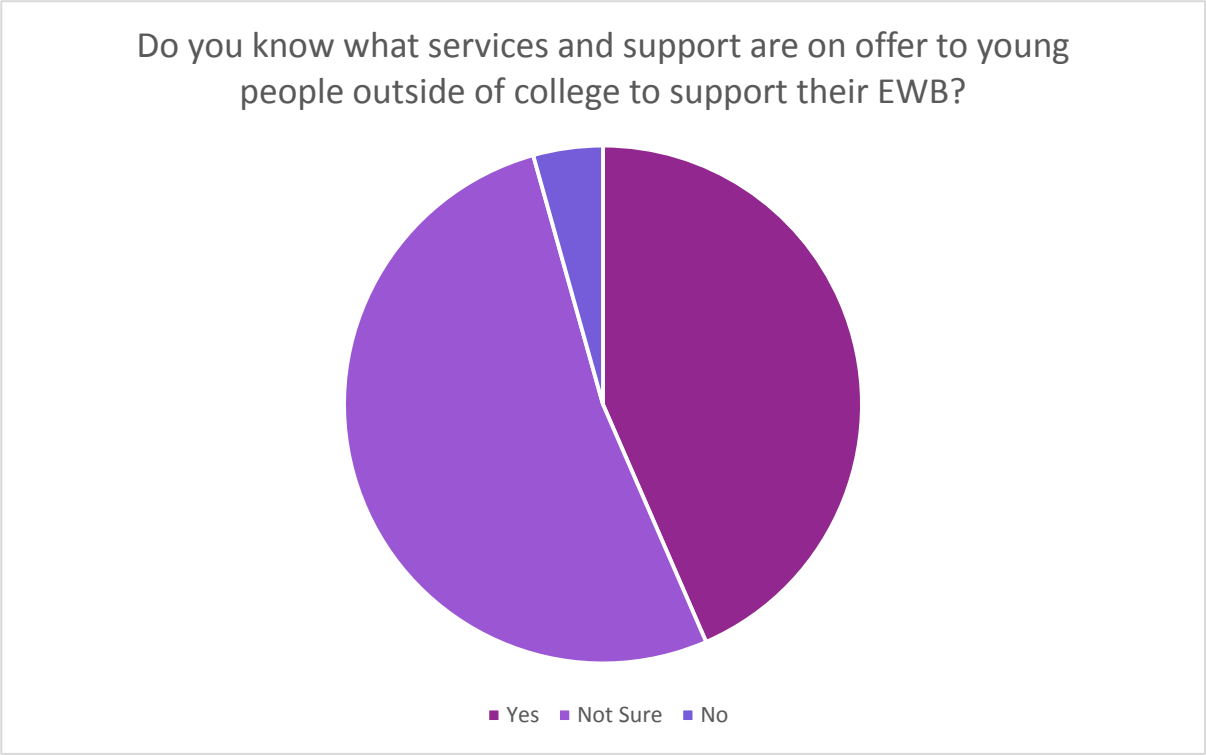


Only 24 of the 39 respondents answered this question (62%). 0% of respondents indicated they did not know what services were available to young people, and only 4 respondents (17%) were unsure. The vast majority of respondents, 20 (83%) indicated that they did know what services and support is available to young people in college to support their Emotional Wellbeing

Of those who felt they did know what services and support were available:

- The most common answers given were: **The Health and Wellbeing Centre, The College Counselling Service,** and **Student Services**
- 2 respondents also mentioned the **IAPT Service** within college

SUPPORT AND SERVICES AVAILABLE OUTSIDE OF COLLEGE



Only 23 of the 39 respondents answered this question (59%). Only 1 respondent (4%) indicated they did not know what services were available to young people outside of college, however 12 respondents (52%) indicated that they were unsure about what services were available. 10 respondents (44%) indicated that they knew what services were available to young people outside of college.

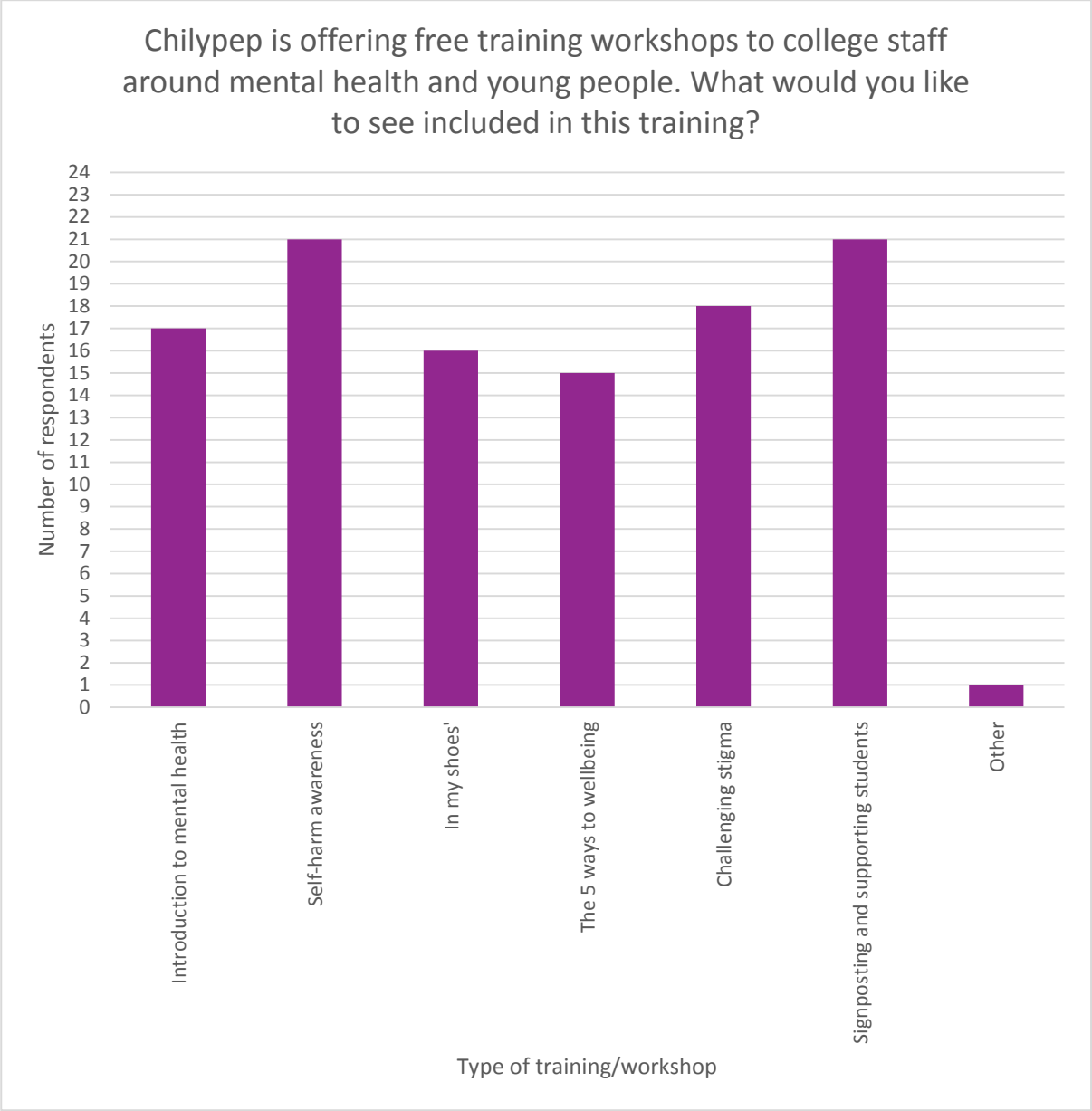
A wide range of answers were given:

- National Charities and NGOs **(Young Minds, MIND, the Samaritans)**
- Local organisations **(BSARCH)**
- The NHS **(GPs, CAHMS, IAPT services)**
- The Council **(Connect to Support Barnsley)**

Recommendation: It is recommended that there be an online resource area for staff with signposting information and services/ support they can access to be able to refer young people to. This could include national organisations and helplines, as well as a mapping of local support services.

TRAINING AND DEVELOPMENT

In order to find out whether staff were interested in receiving training and development from Chilypep around students' emotional wellbeing and mental health, and to shape what this might look like, we asked staff if they would be interested in receiving training and what they would like to be included in this.



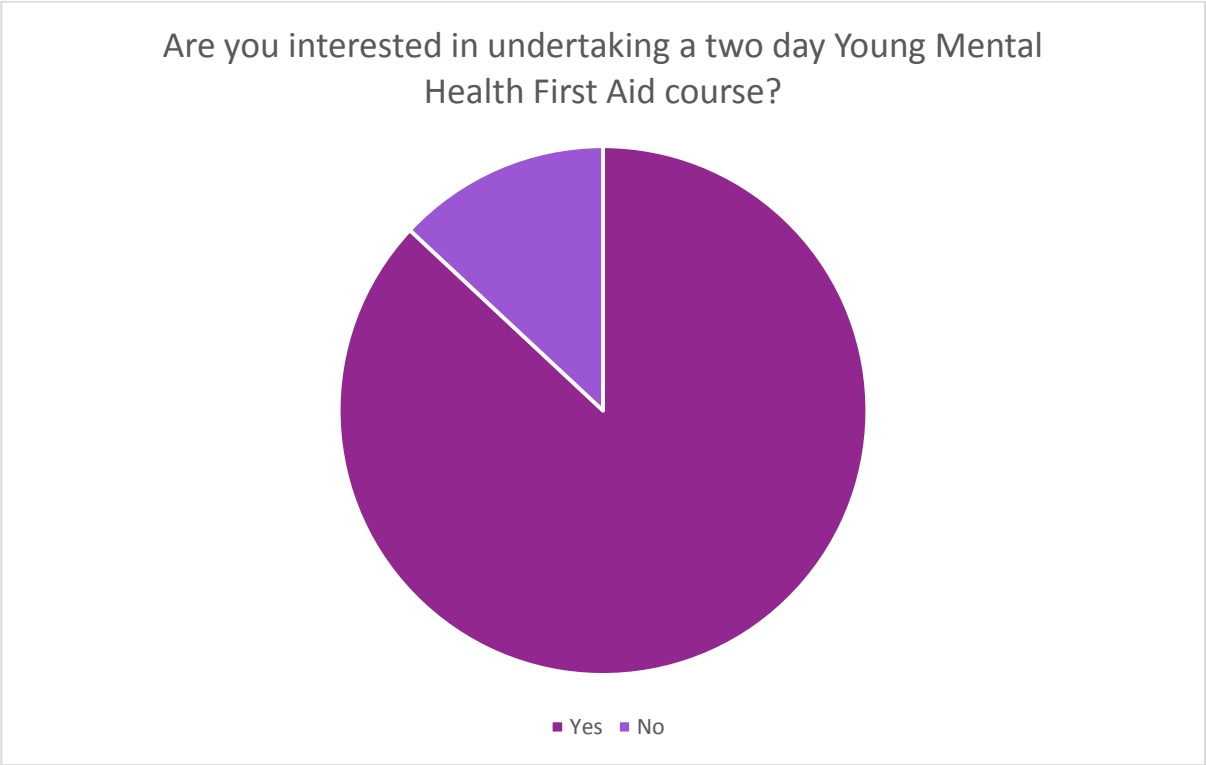
22 of the 39 respondents answered this question (56%), with all but one of the respondents indicated they would be interested in more than one type of training.

Self-harm Awareness and **Signposting and Supporting Students** were the most popular choices, closely followed by **Challenging Stigma, An Introduction to Mental Health, In My Shoes** and **The 5 Ways to Wellbeing**.

The respondent who indicated **Other** said: *"Eating disorders (this is a hugely common problem which is often a secret coping mechanism). I believe that it is often neglected because of this."*

YOUTH MENTAL HEALTH FIRST AID

As part of the training and development of staff Chilypep was keen to offer access to the 'Youth Mental Health First Aid' certificate. This is an internationally recognised certificate, equipping adults with the necessary knowledge and skills to support young people experiencing mental ill health. We therefore asked staff if they were interested in accessing this course.



23 respondents answered this question (59%), with the vast majority of respondents, 20, (87%) stating that they were interested in the training, and only 3 (13%) indicating that this was not something they were interested in doing.

Recommendation: From our consultation it was evident that there is a willingness and desire from staff to undergo further training and development in relation to supporting young people with their mental health. It is therefore recommended that such training be offered to staff on an ongoing basis so as to meet their identified development needs.

STAFF FEEDBACK ON TUTORIALS

Staff present at the tutorials Chilypep delivered to young people across college sites, cited the benefits to both themselves and young people of these sessions. Staff commonly stated that they themselves learnt a great deal during the sessions, and were often surprised at the level of engagement of students within the session.

Below is a sample of some of the feedback we received from staff:

> The sessions … sound really interesting and extremely useful for students

> The 'chilled out' and open environment makes [students] able to talk without fear of judgement.

> This is absolutely fabulous

> Outstanding, brave and inspirational presentations

> We will welcome you in from September if that is possible

> The workshop was very active and engaging and a positive response was given by learners

> Just. Wow. Thanks very much to all of you! Keep up the amazing work!

> All staff agreed that it would be of great benefit to have a programme that ran over a few weeks so that learners could engage as the topic has a high prevalence within our department

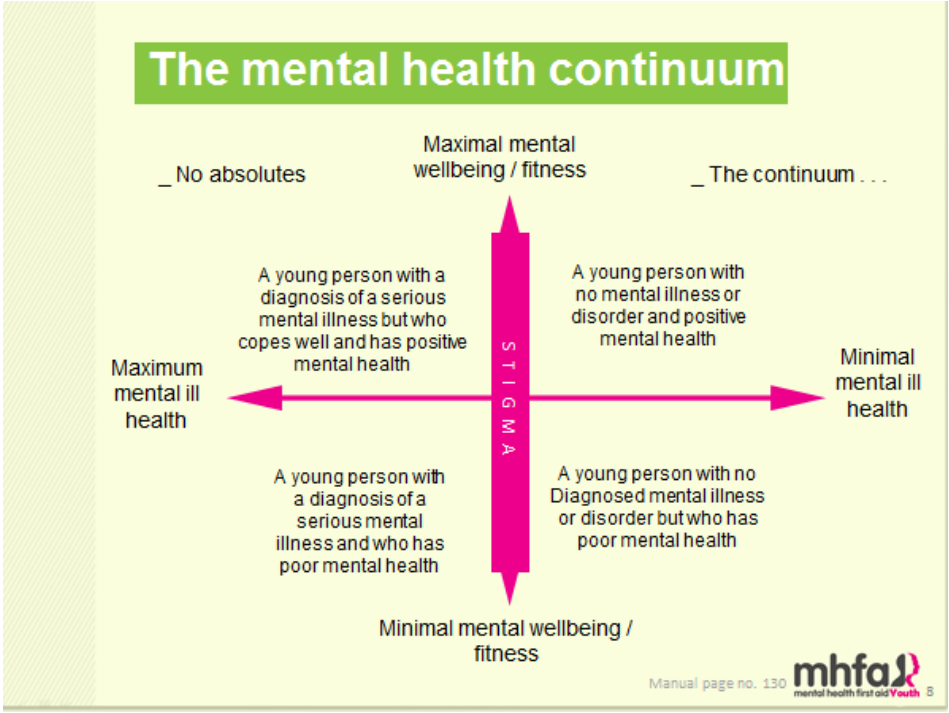
Based on the feedback from the staff survey, Chilypep designed and delivered a two hour workshop to 18 front facing college staff.

The workshop included:

- Introduction to mental health
- Signs & Symptoms of mental ill health
- Risk factors for mental ill health in students
- 'In My Shoes' workshop exercise
- Responding to, and signposting for, mental health

Much like our young people's training offer, the training workshops with staff involved interactive and engaging methods of delivery to ensure active learning and participation.

The session began by exploring 'what is mental health', using similar methods as were used with young people; this included a board blast around mental health vs physical health. As we found in tutorials with young people, 'mental health' was more commonly associated with negative words, and stigma, whereas 'physical health' brought up language such as 'exercise', and 'healthy eating'.



In order to look at the signs and symptoms of mental ill health, and risk factors for students staff were asked to design their own character, painting

a picture of what their world may look like. The case studies related to the four quadrants of Mental Health First Aid England's 'Mental Health Continuum'.

'In my shoes' is a workshop that was developed with STAMP to explore the experiences of young people in relation to mental health; the issues young people face, the systems they have to navigate, and the struggle to find support. This exercise involves a volunteer sitting in the middle of a circle, with their eyes closed, whilst those around them read out young people's stories. The idea is that the person in the middle takes on the stories as if they were their own, and feedbacks to the group how it felt to be that young person, highlighting key issues back to the group. This exercise has proven to be very successful, with participants able to 'step into the shoes' of young people and their lived experiences around mental health.

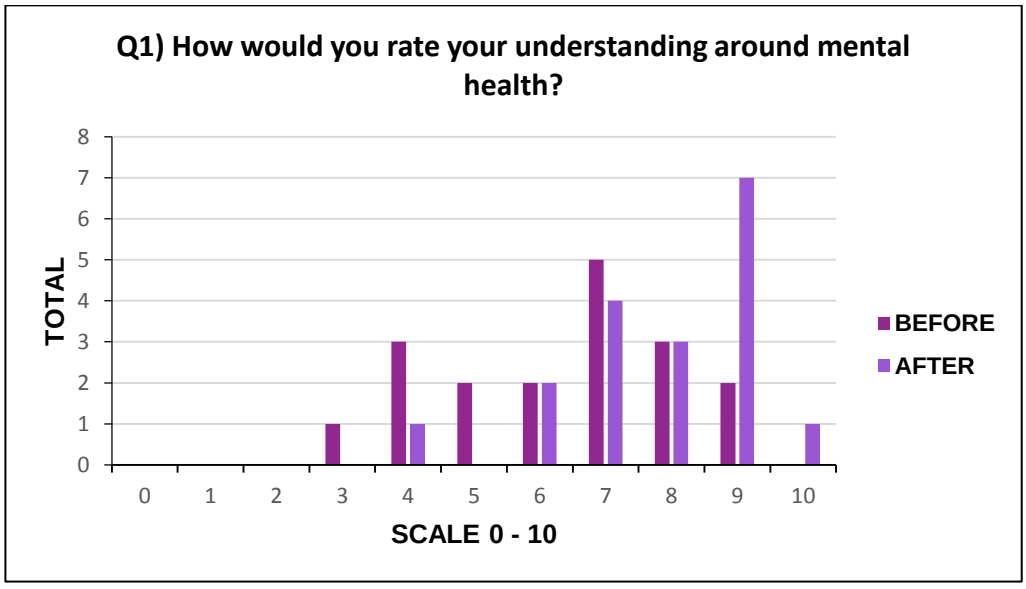
Through our initial research with staff, signposting information came out as an area for development, with staff wanting to receive more training around supporting and signposting young people to services, both within and outside of college. The final part of the workshop therefore focused on ALGEE, the five steps within Youth Mental Health First Aid, as well as a look at where staff could signpost young people to.

OUTCOMES OF THE WORKSHOP

Throughout the workshop staff remained engaged, taking part in all activities and asking questions and sharing their own experiences in relation to supporting students and young people.

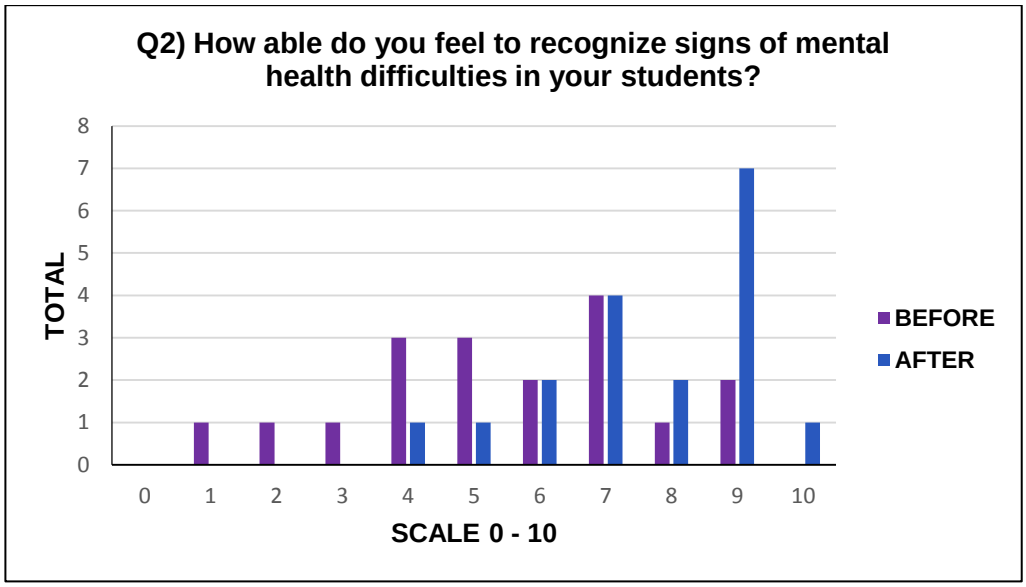
In order to evaluate the workshop we carried out a baseline assessment of staffs understanding around mental health, ability to recognise signs of mental health difficulties in students, and their confidence to talk to students around their mental health.

Increased confidence in understanding of mental health



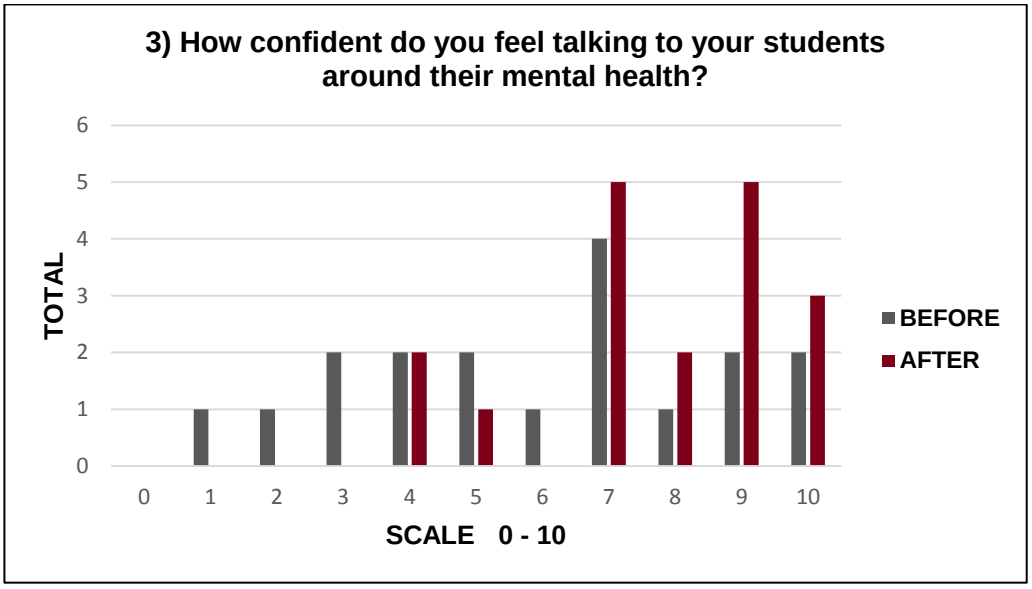
- 95% of participants reported an increased understanding around mental health following the workshop.
- 1 participant felt they had a decreased understanding following the workshop. They said that this was due to the fact that on delving into mental health in more detail they had realised that they did not know as much as they had first thought.

Increased ability to recognise signs of mental ill health in students



- 84% of participants reported that they felt more able to recognise signs of mental ill health in their students following participation in the workshop.
- 11% reported no change
- 5% reported a decrease in their ability to recognise signs of mental ill health in students.

Increased confidence to talk to students about their mental health



- 73% of participations said that they felt more confident following the workshop to be able to talk to students about their mental health.

- 17% felt less confident following the workshop around talking to students about their mental health. One participant commented that they felt there was a lot more to mental health than they had first considered, and this made them nervous in terms of being able to support students and talk to them about mental health.

What did you gain from the workshop?

It was good to have the whole team experience this training. I am a certified peer support trainer so this is great for others in our team.

A better understanding of supporting signs of mental health issues.

How to speak to students who are suffering from feeling down, for instance discuss ways to make them feel better.

In my shoes gave me a real insight.

How to positively help young people and recognising signs and how to help them and taking a more positive approach to helping.

Already had an understanding but helped reassure extra information.

More confident that I could recognise signs of mental health issues

I found it useful and would like to look into the mental health first aid more – thank you!

I feel able to recognise the signs of mental health difficulties now.

Gained more confidence in speaking to students about their mental health and reminder to think more about external/ home factors.

Confidence to talk to students about their mental health as they must need someone to talk to if the issue is raised.

Mental health issues should be dealt with seriously and professionally; in education we should be regularly kept in the know, alert and in line with other colleagues.

Could anything be improved?

Include case studies around adults

I enjoyed the activities so activities are good!

More visual aids

Longer workshop

More strategies on speaking to students about mental health

YOUTH MENTAL HEALTH FIRST AID TRAINING

12 members of staff from Barnsley College underwent the Youth Mental Health First Aid Training on 29th and 30th June.

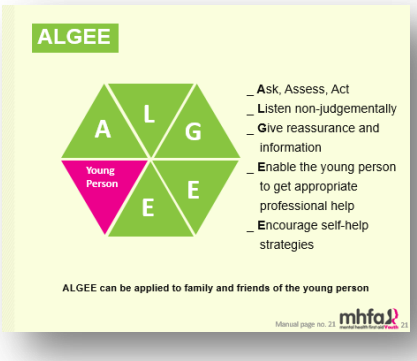
Youth Mental Health First Aid is an internationally recognised coursed designed specifically for those people who teach, work, live with or care for young people aged 8-18. The course is split into four sections:

1. **What is mental health?**
2. **Anxiety and depression**
3. **Suicide and psychosis**
4. **Self-harm and eating disorders**

Within each section, participants learn how to:

- Spot the signs of a mental health problem in young people
- Feel confident helping a young person experiencing a problem
- Provide help on a first aid basis
- Help protect a young person who might be at risk of harm
- Help prevent a mental illness from getting worse
- Help a young person recover faster
- Guide a young person towards the right support
- Reduce the stigma of mental health problems

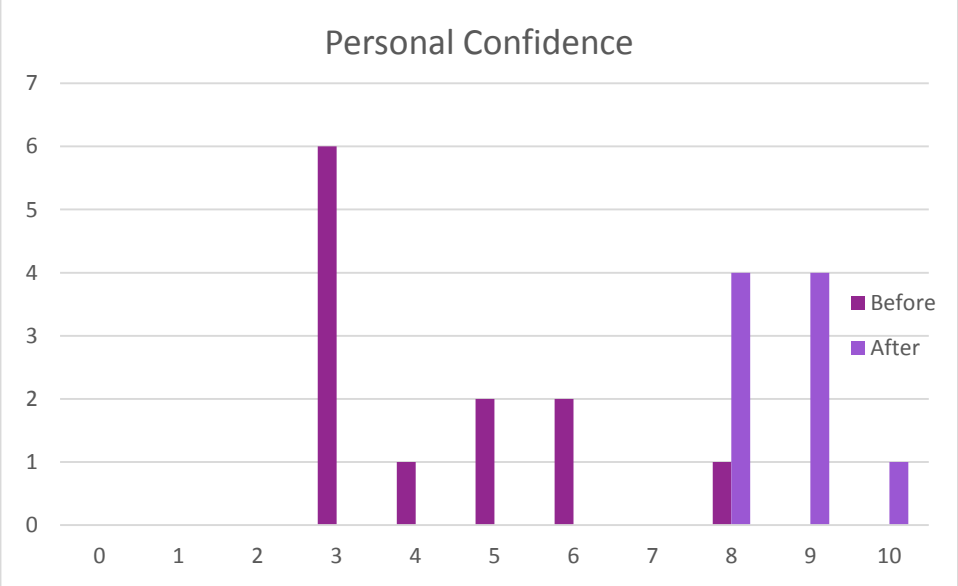
Youth Mental Health First Aid is different to a basic mental health awareness workshop, both in the depth it goes into, and the use of 'ALGEE', the steps to take in relation to mental health first aid.



The course is a two day certified course, giving participants the opportunity to really explore mental health and young people, and develop their knowledge around mental health, whilst also gaining practical skills to enable them to support young people.

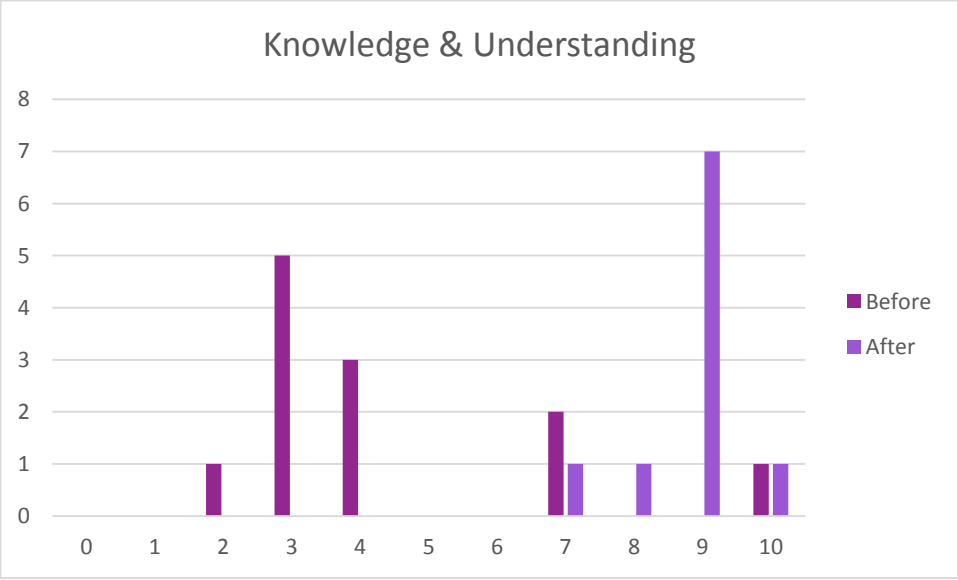
In order to evaluate the impact of the training on staff, we carried out a baseline questionnaire looking at staff's confidence in supporting young people with their mental health, their knowledge and understanding around mental health. The same information was then captured at the end of the two days. In addition to this we gathered information around course content, delivery methods, and materials. A more in-depth evaluation capturing this information can be found in the appendix.

CONFIDENCE TO SUPPORT YOUNG PEOPLE – BASELINE DATA



- 100% of participants reported an increase in their confidence to support young people around their mental health following the two day course.

KNOWLEDGE AND UNDERSTANDING – BASELINE DATA



- 100% of participants reported an increase in their knowledge and understanding around young people's mental health following the two day course.

HOW WOULD YOU RATE THE INSTRUCTORS?

100% of staff rated the instructors as ‘very good’:

“Both instructors were engaging, professional, listened and answered questions”.

“Very confident. Informative.”

“Excellent trainers. Knew slides inside out”.

“Good, informative, flowed well.”

FEEDBACK

“Really enjoyed the course. Lots of detailed information. Would recommend to other staff. Thanks”

“I put environment as I didn’t like the rooms very much. Loved the active listening and hearing voices exercises. This has been really worthwhile. I have learnt so much.”

“Both instructors were very helpful. I felt like I could ask them anything without being judged, no matter how silly some questions seemed. Knew everything what they was on about and overall very good training to do. I enjoyed it.”

“Both instructors provided specialist information in different areas. E.g. substance misuse/ mental health. Adapted to the needs of the group. Haribos were a winner ☺”

“Very informative. Delivered very well by evidently informative staff/ instructors.”

“The presentation allowed me to understand the definition and different ways of mental health.”

“Very interesting trainers and excellent trainers who clearly knew their subject”.

KEY LEARNING AND RECOMMENDATIONS

SUMMARY AND KEY LEARNING

The College staff were open to and supportive of the pilot and welcomed the project and staff. This helped greatly with getting the project going and developing it across all the sites. The project was highly visible and students and staff were aware of and engaged with it.

The Youth Work approach of the project was different to the day to day activity in the College, but worked really well and showed how informal methods of engagement and activity can complement a more formal structured learning environment. This was partly due to the shared ethos of the College and Chilypep, both organisations having the benefit and development of young people at their core.

Emotional Well Being Champions made a commitment to the project and most stayed throughout. They reported a significant improvement in their own understanding and well-being and want to carry the work on, having written a proposal of what they would like to do. They also engaged in other projects and activities outside college

The tutorials were a great success, and showed how even a short intervention can have a significant impact on students understanding and well-being. The interactive and participative methods used appealed to staff and students and engagement was high. They provided and opportunity for some young people to seek additional help and support, who said they would otherwise not have done so.

College staff gained confidence and greater awareness from the tutorials, workshop and Youth Mental Health First Aid training, and requested more training for more staff across the College.

Although much was achieved, the project would have achieved more if we had been able to start at the beginning of the College year.

It has been difficult to gain information on the effect of attainment and attendance as the College was winding down before we had completed the work and we didn't give enough notice as to when we would need the information, as we are not used to working to 'term time' timetables.

There was not sufficient time to embed the Peer Mentors into the college and at the point young people were ready to begin this role the college was winding down. A project such as this needs a minimum of 18 months, ideally 2 College Years, to train Peer Mentors, set up the systems for them to be able to operate, and train staff so that they can support them to carry on.

RECOMMENDATIONS: EDUCATION AND AWARENESS

1. **Embed an interactive and engaging educational offer that involves young people from the start**

All students need to be taught about the signs and symptoms of mental ill health to enable them to seek help early on. Building the emotional intelligence of young people at an early age will help young people to develop their own coping strategies and resilience, preventing them from becoming unwell when they notice their own wellbeing slipping. It is therefore recommended that schools and colleges embed mental health across the curriculum, ensuring that all students are able to have open discussions around mental health and emotional wellbeing.

Chilypep engaged 265 young people in college tutorials from November 2014-March 2015. Feedback from young people and tutors was that, due to the sessions being delivered in a creative and interactive way, students readily engaged within the topic areas. Young people and tutors highlighted the value of external speakers coming in to engage in this work. It is recommended that when designing a school or college educational offer around mental health and emotional wellbeing that this be designed in consultation with young people, involving them from the start in choosing which elements of mental health they would like to explore, and working with students to develop delivery methods for this that they will engage well with.

2. **Establish a safe and supportive environment where students can openly explore mental health and emotional wellbeing**

At the beginning of each session Chilypep staff and volunteers worked with young people to develop group agreements for the session in order to create a safe and supportive environment. Young people and college staff said that they valued having external workers come into the college to run sessions with them, and that the youth work style of delivery helped to make the sessions feel fun whilst also fostering an open space for discussion.

“I think that what you've been doing is just the right tone and is certainly helping students to identify areas within their own lives that might need addressing. The 'chilled out' and open environment makes them able to talk without fear of judgement. I also think that they are showing real acceptance of students with mental health issues. I don't know if you saw but a couple of student gave the student who had to leave a hug and some kind words when they passed him on the corridor....it actually made me fill up. You're doing really good work.” *Tutor, Barnsley College.*

3. **Encourage and enable peer to peer learning**

Chilypep trained some of our Emotional Wellbeing Champions in facilitation skills to enable them to co-deliver tutorial sessions across the college. This was a great confidence booster for the Emotional Wellbeing Champions and also encouraged peer to peer learning, something which young people have told us they value.

During one tutorial, one of the Emotional Wellbeing Champions, after showing 'Stand Up Kid' to the class, himself stood up and disclosed his own story around his mental ill health. This in turn encouraged students within the class to share their own experiences and helped to create a safe space for shared learning, whilst also breaking down some of the stigma associated with mental health.

4. **Work with young people to co-design services**

Barnsley College have their own student 'wellbeing centre' on site. The majority of young people we spoke to were aware of the centre, but numbers of young people accessing it were comparatively low. It is recommended that schools and colleges work with young people to co-design mental health and emotional wellbeing services within colleges so that they meet the needs of the young people who use them. More information and guidance around involving young people in mental health service design and commissioning can be found at www.chilypep.org.uk

RECOMMENDATIONS: PEER SUPPORT MODELS

1. **Involve young people from the start**

Peer support models in improving the emotional wellbeing of young people. By involving young people from the start in shaping what they wanted the peer support group to look like gave young people ownership over the project and enabled them to meaningfully influence the project design and delivery. Young people were able to name the group themselves, come up with their own project plans and training requirements, and steer the project from start to finish. This meant that it met their own needs, and was young person friendly and engaging to the wider college student population. It is recommended that this youth led model be used within all whole school and college approaches to mental health.

2. **Provide training to support young people's involvement**

In order to meaningfully participate, young people require training and development as identified by them. It is recommended that workers support young people to come up with their own personal and professional development plans and design training in partnership with young people. The skills young people gain can in turn improve their own mental health and emotional wellbeing, as well as supporting them to achieve and aspire.

3. **Take the time for young people to learn about mental health and emotional wellbeing and develop their own resilience and coping strategies**

When working with young people with lived experiences of mental health it is vital to take time to enable young people to learn about mental health and develop their own resilience in relation to their own mental health and emotional wellbeing before they can go on to support their peers. This includes working with young people to explore common mental health issues young people and adolescents may face, and developing coping strategies and resilience building in relation to these.

4. **Be flexible and enable young people to steer their own project developments**

Meaningful youth-led participation projects naturally grow and develop as young people themselves grow in confidence and become engaged in project design and delivery. It is important to be flexible and enable and encourage young people to steer their own project developments. Within Barnsley College young people instigated additional activities relating to mental health promotion, such as running their own anti-stigma events, taking part in film-making projects to raise awareness about mental health, and engaging in mental health campaigns outside of the college setting. Being able to have a voice and influence within one's community is a protective factor for young people's mental health and should be supported and encouraged as part of any peer led project.

5. **Ensure there is sufficient capacity and resources in place to sustain young people's meaningful involvement**

Towards the end of the Barnsley College Pilot Chilypep worked with the Emotional Wellbeing Champions to develop future plans around their peer support project. This included training tutors in Youth Mental Health First Aid to enable them to 'buddy' the Emotional Wellbeing Champions and support them to further develop the peer support offer within college. However without a trained dedicated staff member to continue to meet with the group on a regular basis, offering them ongoing contact, support, training and advice, sustaining young people's meaningful involvement will be difficult. It is therefore recommended that when thinking about setting up a peer support project that there be sufficient capacity and resources committed for a sustained period to enable young people's meaningful and ongoing involvement.

RECOMMENDATIONS: STAFF TRAINING AND DEVELOPMENT

1. **Put in place an ongoing mental health and emotional wellbeing training offer to school and college staff**

Whilst the majority of staff indicated that they had a moderate to high understanding around mental health, just 52% of staff we consulted with felt able to recognise the signs of mental ill health within their students. In initial tutorial consultations with staff many stated that whilst they felt they had a basic understanding around mental health, they did not always feel confident working with students around mental health and could benefit from further training.

It is recommended that there be an ongoing training offer to staff across college sites in relation to mental health and emotional wellbeing. It is recommended that any training offer to staff within college be informed by staff and designed, and where possible delivered, by/with young people. The college may want to consider having mental health as a standing item on team meetings, and putting in place designated 'go to' staff acting as mental health champions within their teams.

2. **Enable effective information and signposting for young people**

Our research showed us that young people often do not know where to go for support around their mental health. Staff who completed our research were aware of services in college but knowledge of support outside of the college environment was more limited. It is important to be able to give young people effective information and signposting following tutorial to enable them to access support as required. Teachers and tutors should be trained around signposting and support available to young people to enable effective signposting to take place. It is recommended that there be an online resource area for staff with signposting information and services/ support they can access to be able to refer young people to. This could include national organisations and helplines, as well as a mapping of local support services.

Future work could include working with the Emotional Wellbeing Champions to carry out a mapping of support and services in the local area. They could then develop a 'where to go' information leaflet or online forum that students could access to find help and support.

3. Involve young people in the recruitment and training of staff

Previous research undertaken by Chilypep has revealed the importance of relationships within mental health support, and college environments. Young people want to seek support from teachers or other professionals that they feel understand them and from those who have a genuine interest in supporting them. It is recommended that young people be involved in the recruitment and training of staff.

4. Encourage joined up working

Some young people said they would not feel comfortable talking to a member of staff around their mental health, but would prefer to seek support outside of the college environment. It is therefore recommended that schools and colleges collaborate with external organisations and agencies to build on their emotional wellbeing support offer and to give young people a choice about the sort of support they may want to access.

RESOURCE BANK

Mental Health Apps & Websites for young people

Innovation Labs: http://www.innovationlabs.org.uk/

A site with useful apps and sites designed with/by young people around mental health. Including:

Doc Ready – help and support preparing for a GP visit

Find Get Give – signposting website

Madly in Love – Platform for young people around relationships

Mood bug – mood app

Well informed – for professionals working with YP around MH

In Hand – recovery app

Head Meds – Information about medication for YP

NHS Choices: Health Apps library http://apps.nhs.uk/

Epic Friends: http://epicfriends.co.uk/ - site for young people with lots of information about MH and how to support their friends

Feeling H-Appy? A young person from STAMP (Chilypep participation group) review of mental health apps: https://stampsheffield.wordpress.com/2012/11/07/feeling-h-appy/

Action for Happiness: http://www.actionforhappiness.org/

NORMEN – Self Harm Conference Downloads: Loads of really useful resources for working with self- harm http://www.asknormen.co.uk/self-harm-and-suicidal-ideation-conference-resources/

Films & Talks

'On the Edge': A film made by young people from STAMP (Chilypep mental health participation group) detailing their experiences of Mental health crisis and crisis care services https://www.youtube.com/watch?v=px5boQGN66I

Young Carers Need Care Too: A film made by young people from VOYCE PG (Views of Young Carers Explained) in partnership with Fixers UK, highlighting the issues affecting young carers https://www.youtube.com/watch?v=_5pfgvFGSi4

Move Forward with Mental Health: A film made by young people from STAMP in partnership with Fixers UK, highlighting young people's experiences around mental health and the need to 'Move Forward' with mental health https://www.youtube.com/watch?v=k5o5ei_FxFA

The Voices in my head: Eleanor Longden's TED Talk on her experiences of living with voices https://www.youtube.com/watch?v=syjEN3peCJw

Stand Up Kid: https://www.youtube.com/watch?v=SE5Ip60_HJk

Mindreel | Mental health film resource: Mindreel is an initiative to create a valuable learning resource using educational films that about mental health.
mindreel.org.uk/

Useful sites for further information & reports

http://www.right-here.org.uk/resource-centre/

http://www.youngminds.org.uk/

http://www.mentalhealth.org.uk/

http://ww.chilypep.org.uk/

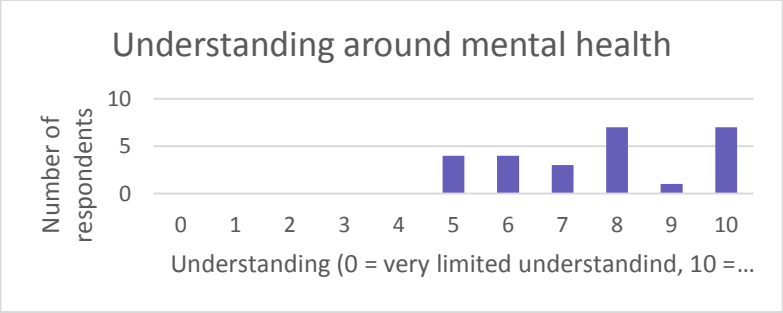
APPENDIX

YOUNG PEOPLE'S FEEDBACK

26 college students completed a questionnaire on emotional wellbeing and mental health. They were asked nine questions, both closed and open-ended, in relation to their knowledge and understanding around mental health, the services available to them at college, and their key areas of interest in relation to mental health.

QUESTION 1

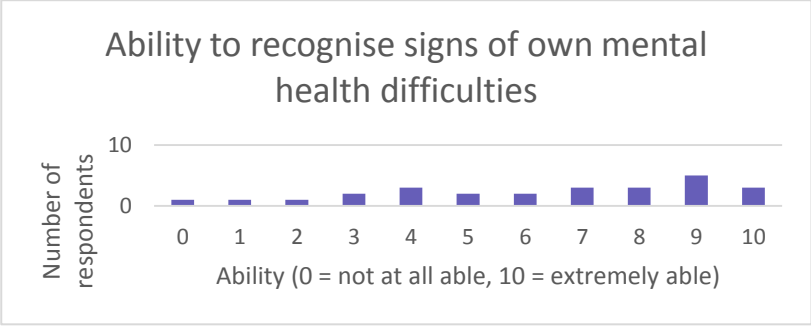
On a scale of 0-10 how would you rate your understanding around mental health? (0 = very limited understanding, 10 = very comprehensive understanding)



- All 26 respondents answered this question
- 100% of respondents indicated at least an average understanding around mental health (indicating 5 or more)
- 15 respondents (58%) indicated a very comprehensive understanding around mental health, answering 8, 9 or 10

QUESTION 2

On a scale of 0-10 how able do you feel you can recognise signs of your own mental health difficulties? (0 = very limited ability, 10 = very comprehensive ability)

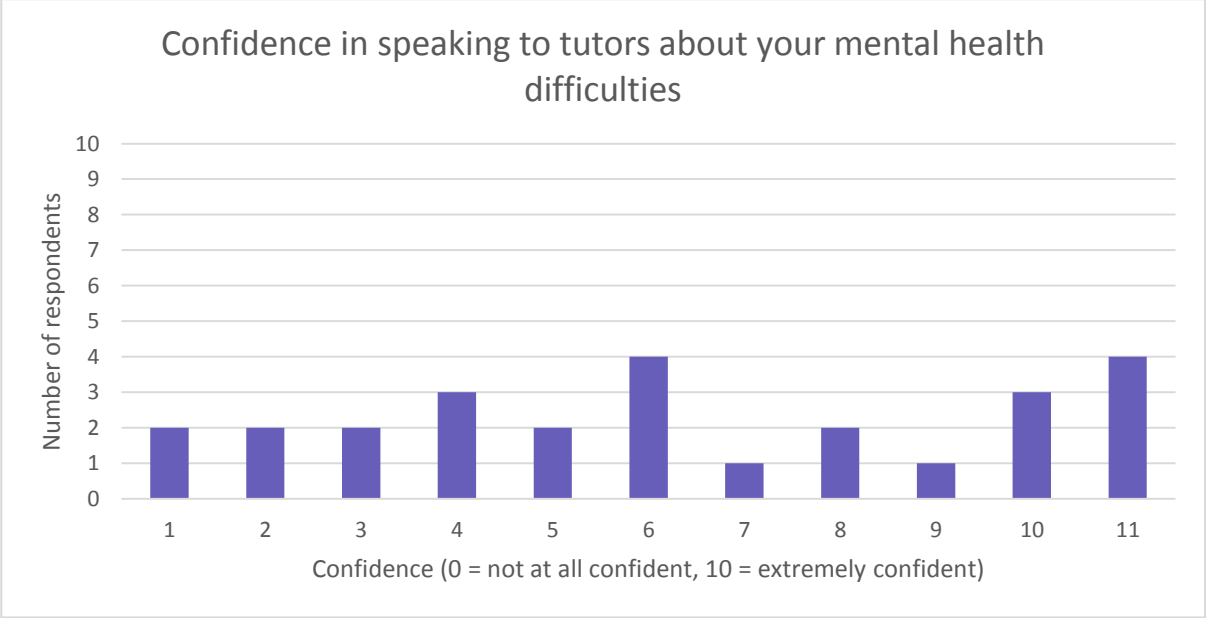


- All 26 respondents answered this question
- The responses to this question were varied, with each number being indicated at least once. This indicates that there was a broad range of ability to recognise signs of own mental health difficulties amongst respondents

- However, the majority of respondents, 18, (69%) indicated they had an above average ability to recognise their own mental health difficulties by answering 5 or more

QUESTION 3

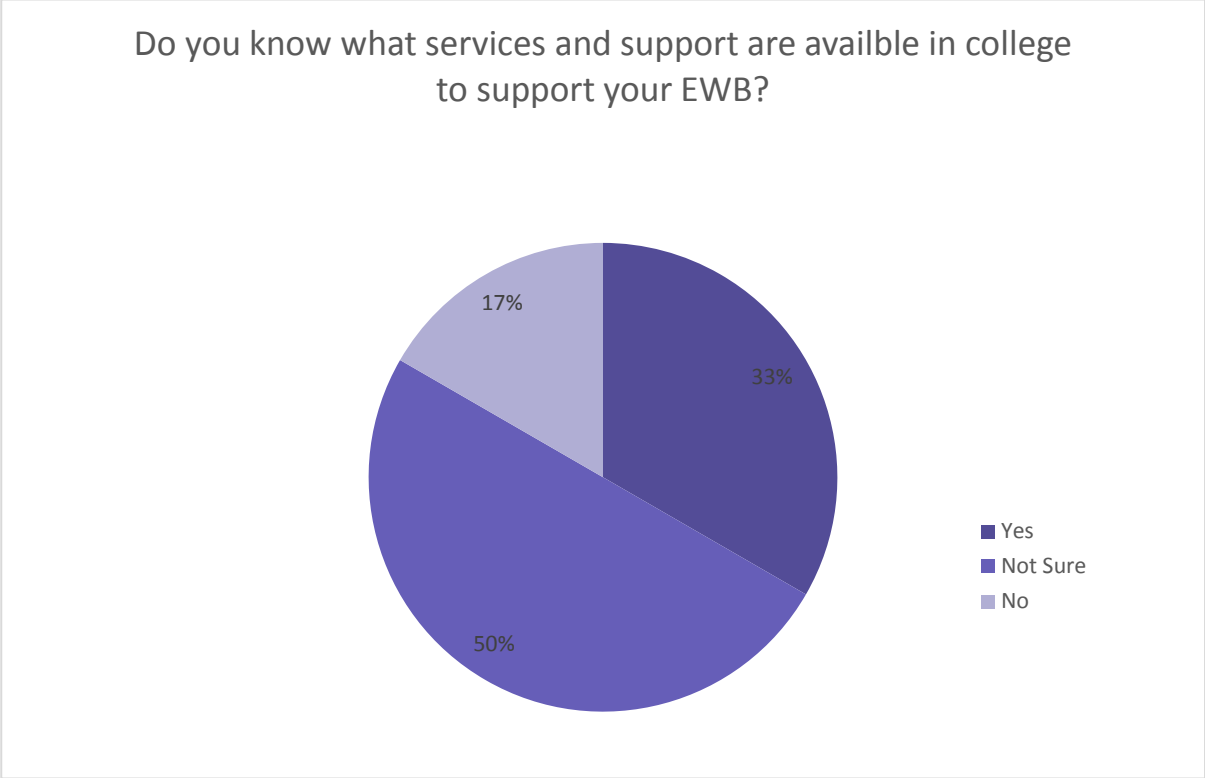
On a scale of 0-10 how confident do you feel talking to your tutors around your mental health? (0 = not at all confident, 10 = very confident)



- All 26 respondents answered this question
- There was a broad range of respondent's confidence in talking to tutors about mental health, with each number being indicated at least once.
- The greatest percentages of respondents (15%) were either: neither confident nor unconfident in talking to their tutors about their mental health (indicating 5); or were very confident in talking to tutors (indicating 10).
- 39% of respondents had a less than average confidence in talking to their tutors about their mental health (indicating 0-4)
- 42% of respondents had a greater than average confidence in talking to their tutors about their mental health (indicating 6-10)

QUESTION 4

Do you know what services and support is available to you in college to support your EWB?



- 25 of the 26 respondents answered this question
- Half of the respondents (50%) were unsure what support is available in college to support their emotional wellbeing
- 33% of the respondents were aware of what mental health services/support is available in college, whilst 17% of the respondents indicated that they were unaware.

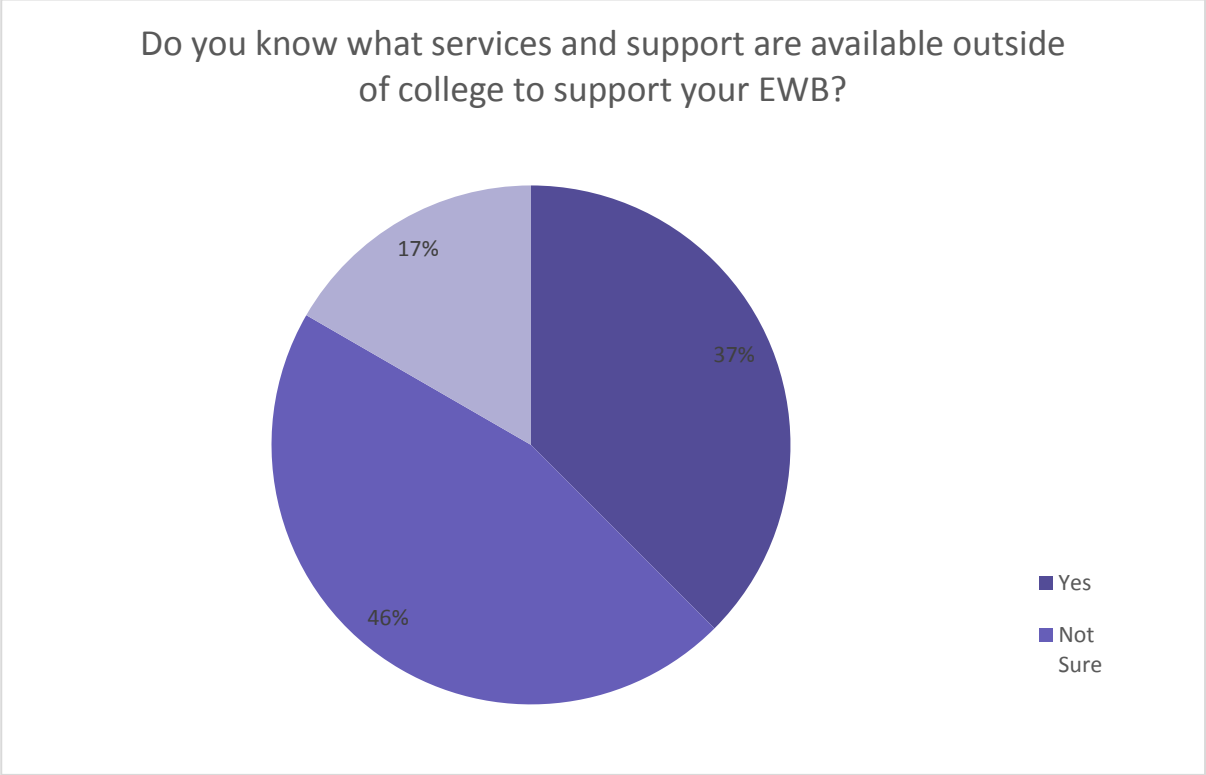
QUESTION 5

If yes, what services and support are available?

- Health and wellbeing
- Support, health and wellbeing
- Health and wellbeing in main college
- They have got a health and wellbeing centre
- Tutor, wellbeing
- Talking to a counsellor
- Personal tutors

QUESTION 6

Do you know what services and support are on offer to you outside of college to support your EWB?



- 24 of the 26 respondents answered this question
- Over half of the respondents (63%) were either unsure (46%) or totally unaware (17%) of what support and serves were available to them outside of college
- Respondents were more aware of mental health and wellbeing services and support available to them outside of college (37%) than services and support provided to them within college (33%)

QUESTION 7

If yes, what services and support are available?

- Your GP and counselling sessions
- Counselling, friends and family
- CAMHS, your GP, doctors
- You can talk to your doctor and counsellor
- Mental health phone lines, support worker
- Suicide hotline, friends

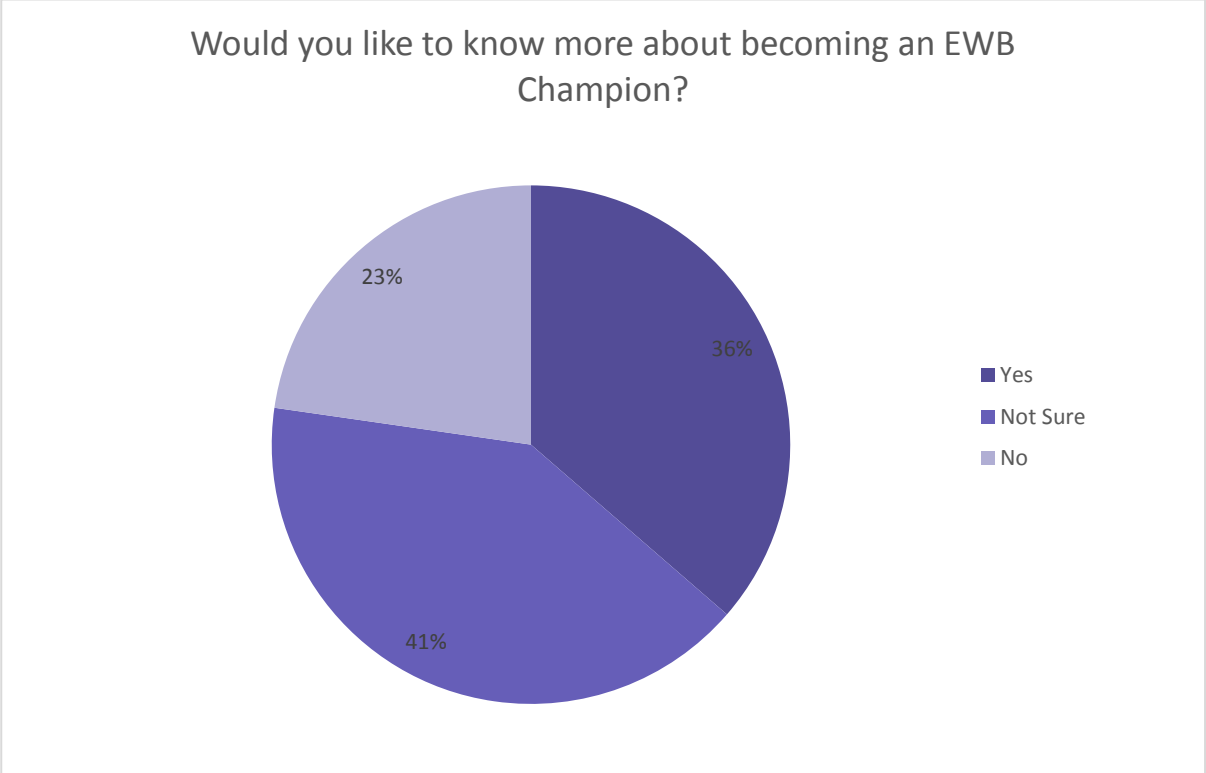
QUESTION 8

Chilypep is offering free training, workshops, residential, aiming at promoting an anti-stigma campaign in college. Also to train young people to be peer educators around mental health. Would you be interested in the below? (tick all relevant)

- 21 of the 26 respondents answered this question
- Respondents were allowed to tick all relevant answers and as such there were 61 responses
- 18 of the 21 respondents to this question indicated more than one type of training that they would be interested in
- The most popular training indicated was an ‘Introduction to Mental Health’, indicated by over a quarter (26%) of respondents
- This was followed by the ‘In My Shoes’ training (18%), The 5 Ways to Wellbeing (16%) and training to become an EWB Champion within college (15%)
- The less popular training opportunities indicated were Self-harm Awareness (13%) and Challenging Stigma (11%). No respondent indicated ‘Other’ (0%)

QUESTION 9

Would you like to know more about becoming an EWB champion for your college?



- 22 of the 26 respondents answered this question
- 36% of respondents indicated they would like to know more about becoming an EWB Champion
- 41% (the largest percentage) of respondents indicated that they were unsure whether they wanted to learn more about becoming an EWB Champion
- 23% of respondents indicated that they did not want to learn more about becoming an EWB Champion

TO BE ENTERED INTO A FREE PRIZE DRAW TO WIN £100 PLEASE TELL US BELOW WHAT YOU WOULD SPEND THIS ON TO IMPROVE YOUR EMOTIONAL WELLBEING

- Things that would make me happy & confident & help me through things
- By putting support groups out there
- I lost my sister in a car crash and there is too many memories in the village so it would be nice to have a weekend break
- Cigs
- By putting support groups out there
- I would spend the £100 on things that would keep my mind occupied buy games for my xbox and clothing, also take my mum out for a meal
- I would give it to charity to help the people who do need it
- I would buy a gym membership and get myself out there. Also I would go to such things like coffee mornings to socialise with others
- I would spend it on a day out with as many people as I can get doing something everyone wants to do (or more than one day out)
- Maybe a short time away to get away from your stress and problems. Going away with a friend where you can have the perfect opportunity to talk about your

problems and ways that you can de-stress with whenever you need to. Find out where you can go for the help

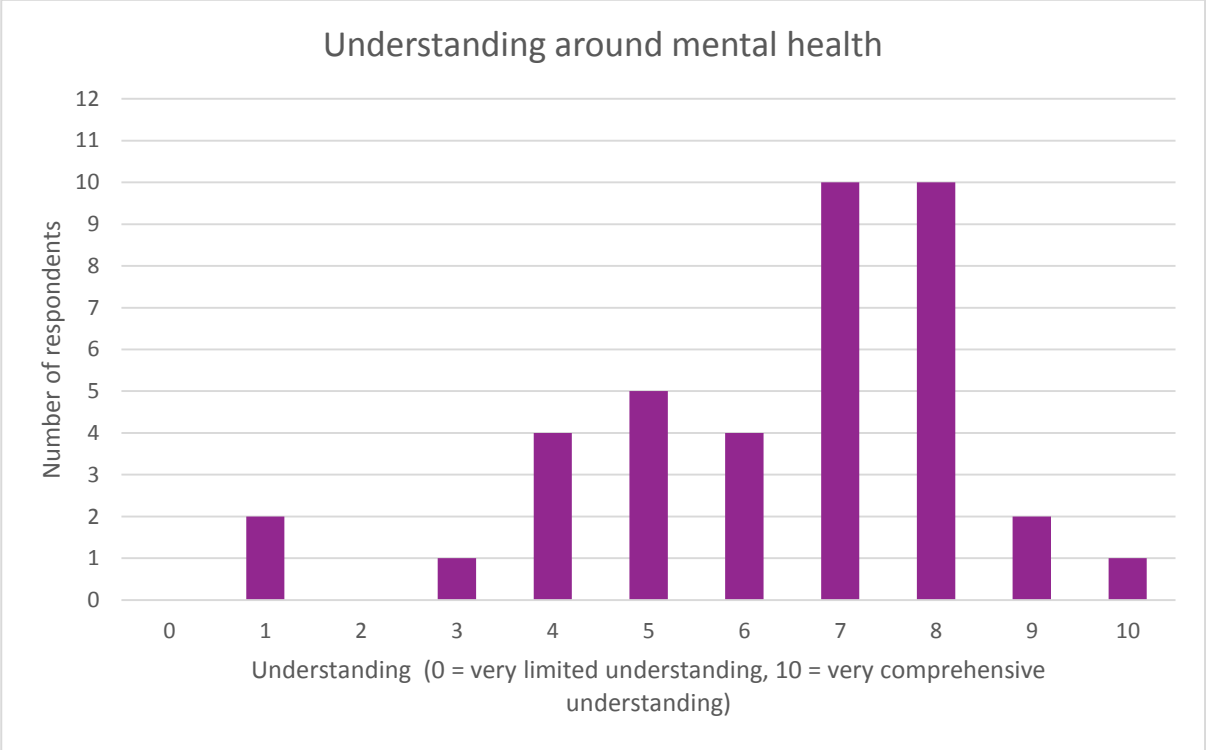
- Gym membership, de-stressing activities
- Buy rugby gear and plan a trip to another country to clear the mind and help the mental aspects
- Learn to drive so maybe I could get a job
- I would buy more fruit and get a gym membership
- I would spend the money on me and my mum to go to a hotel for a night to relax
- A day out with my mum
- Take my family out for a meal somewhere nice maybe go to the cinema as well
- Running shoes, and gym membership
- Buy a Bob Marley album and book a trip out to somewhere like Flamingo Land
- I would save the money because money makes me happy, whenever I have spare money I am much happier

STAFF FEEDBACK

39 members of staff completed a Survey Monkey questionnaire on the mental health and emotional wellbeing of their students. They were asked nine questions, which were both closed and open-ended. They were also asked to give written feedback about the sessions and tutorials given to students by CHILYPEP. 12 staff members also undertook Youth Mental Health First Aid Training, and their feedback from this can be found below.

QUESTION 1

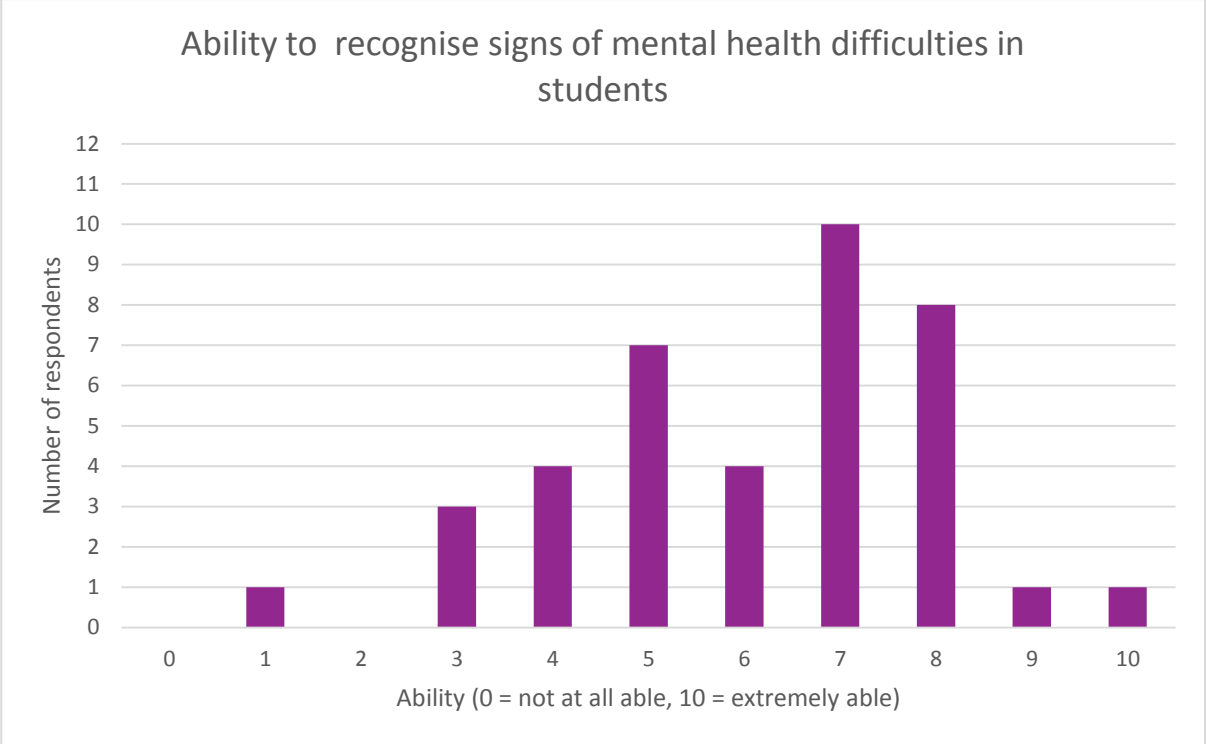
On a scale of 0-10 how would you rate your understanding around mental health? (0 = very limited understanding, 10 = very comprehensive understanding)



- All 39 respondents answered this question
- The understanding around mental health varied, with at least one respondent indicating all but two of the options
- 3 respondents (8%) indicated a limited understanding, and 13 respondents (33%) indicated an average understanding.
- The majority of respondents, 23, (59%) indicated a comprehensive or very comprehensive understanding around mental health

QUESTION 2

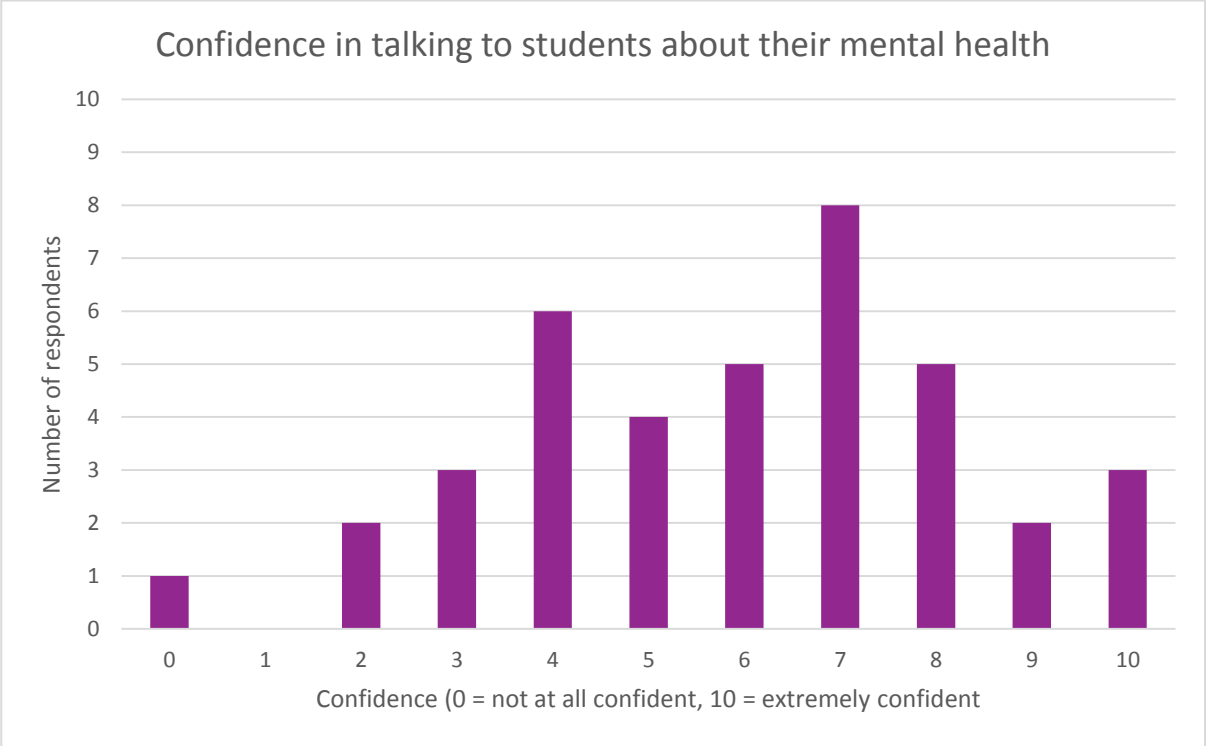
On a scale of 0-10 how able do you feel you can recognise signs of mental health difficulties in your students? (0 = not at all able, 10 = extremely able)



- All 39 respondents answered this question
- The ability to recognise signs of mental health difficulties in students varied with at least one respondent indicating all but two of the options
- 4 respondents (10%) indicated they did not feel able to recognise signs of mental health difficulties in their students
- 15 respondents (38%) indicated they felt somewhat able to recognise signs of mental health difficulties in their students
- The majority of respondents, 20, (52%) indicted they felt able to recognise signs of mental health difficulties in their students. However, of these only 2 respondents (5%) indicated they felt extremely able to do so

QUESTION 3

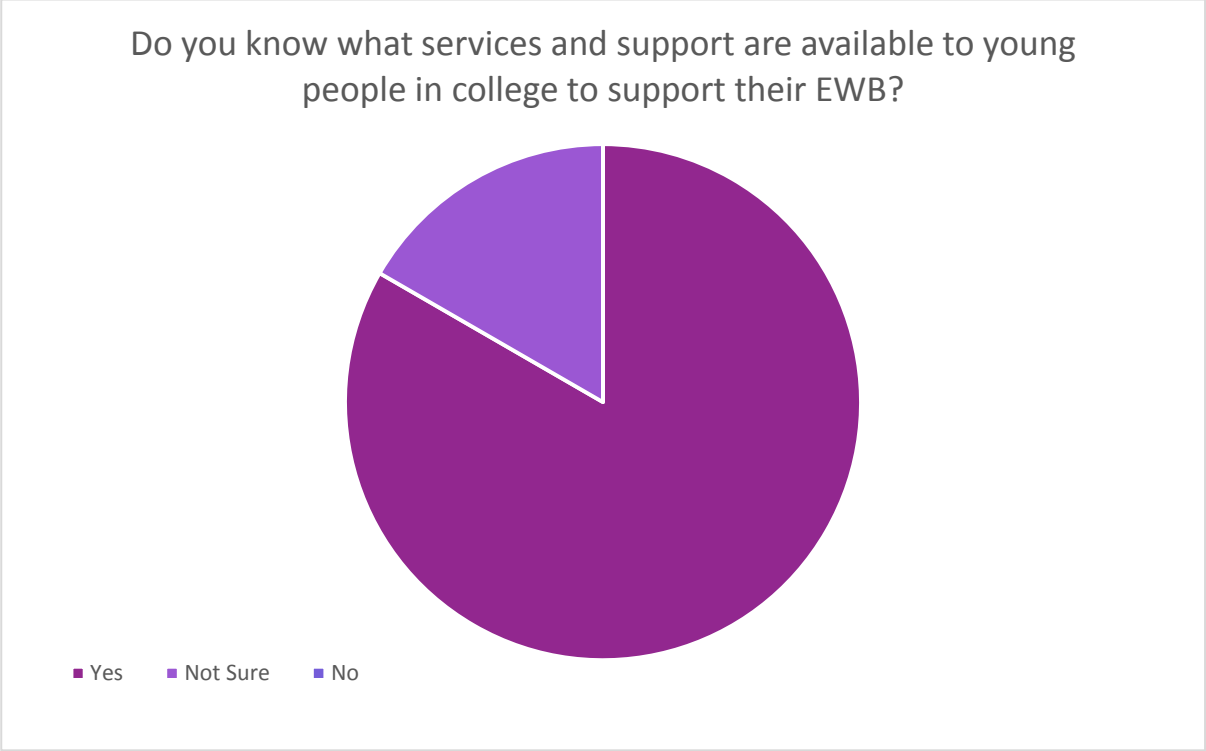
On a scale of 0-10 how confident do you feel talking to your students about their mental health? (0 = not at all confident, 10 = very confident)



- All 39 respondents answered this question
- The confidence staff had on talking to students about their mental health varied, with at least one respondent indicating all but one of the options. There was no clear majority response to this question
- 6 respondents (15%) indicated they had little confidence in talking to their students about mental health, with 1 respondent (3%) indicating they had no confidence in doing so
- 15 respondents (39%) indicated they were somewhat confident in talking to their students about mental health
- 18 respondents (46%) indicated they were confident talking to their students about mental health, with 3 respondents (8%) indicating they were extremely confident

QUESTION 4

*Do you know what services and support is available to young people **in** college to support their Mental Health and Emotional Wellbeing?*



- Only 24 of the 39 respondents answered this question (62%)
- 0% of respondents indicated they did not know what services were available to young people, and only 4 respondents (17%) were unsure
- The vast majority of respondents, 20, (83%) indicated that they did know what services and support is available to young people in college to support their Emotional Wellbeing

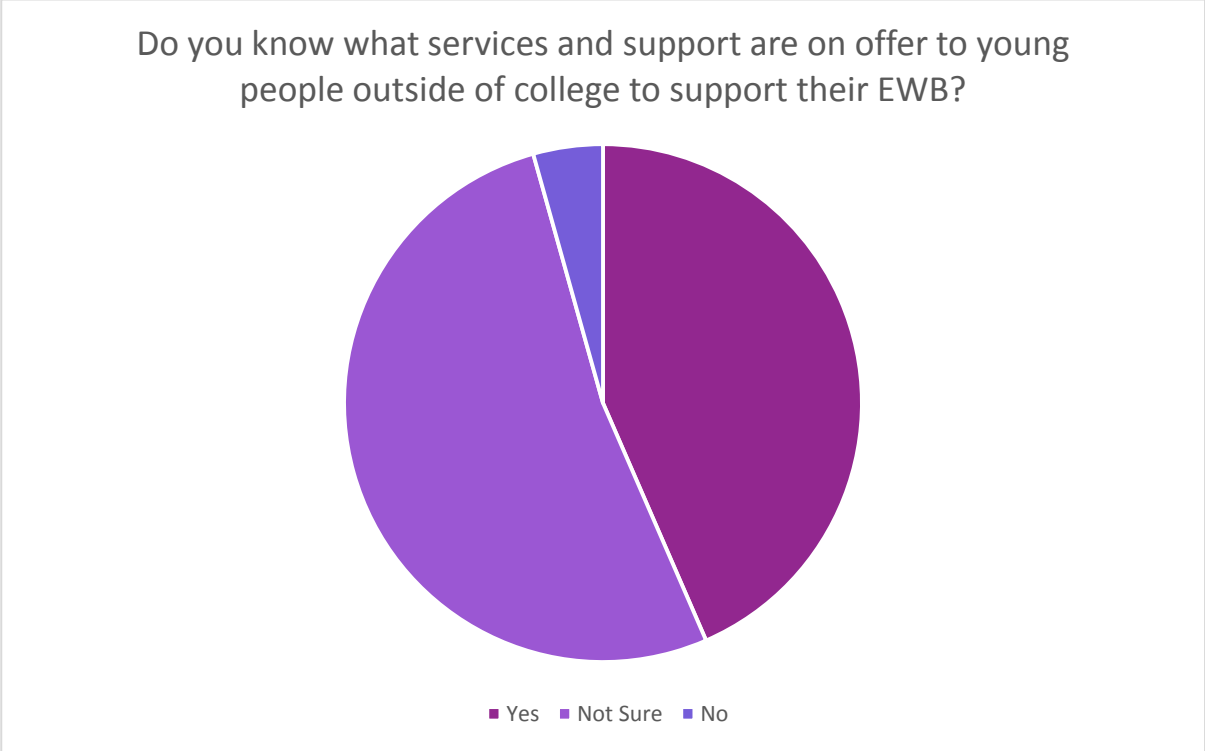
QUESTION 5

If yes, what services and support are available?

- 18 respondents answered this question
- The most common answers given were: **The Health and Wellbeing Centre, The College Counselling Service,** and **Student Services**
- 2 respondents also mentioned the **IAPT Service** within college

QUESTION 6

*Do you know what services and support are on offer to young people **outside** of college to support their EWB?*



- Only 23 of the 39 respondents answered this question (59%)
- Only 1 respondent (4%) indicated they did not know what services were available to young people outside of college, however 12 respondents (52%) indicated that they were unsure about what services were available
- 10 respondents (44%) indicated that they knew what services were available to young people outside of college

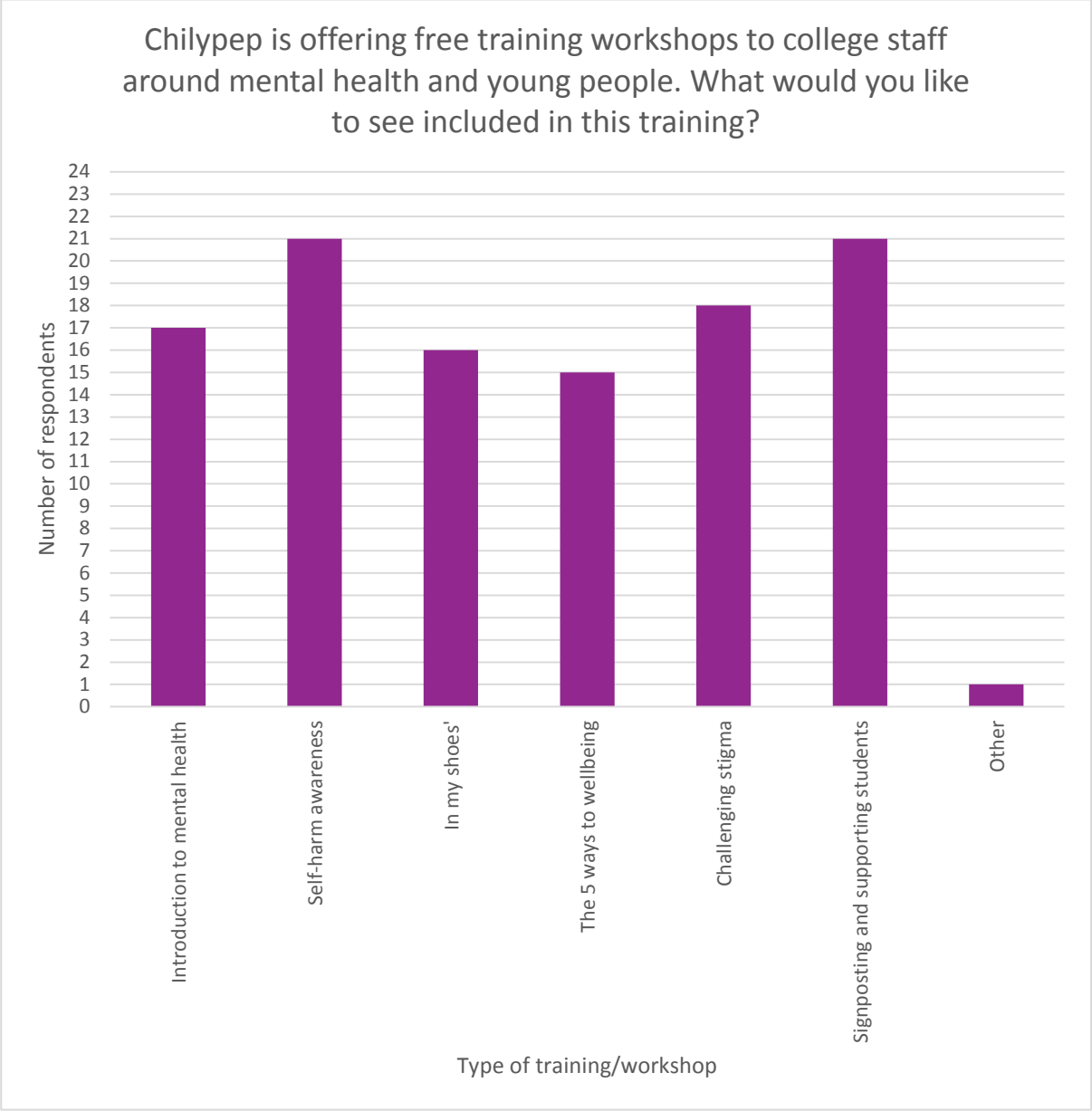
QUESTION 7

If yes, what services and support are available?

- All 10 respondents who indicated 'Yes' to question 6 answered this question
- A wide range of answers were given:
    - National Charities and NGOs **(Young Minds, MIND, the Samaritans)**
    - Local organisations **(BSARCH)**
    - The NHS **(GPs, CAHMS, IAPT services)**
    - The Council **(Connect to Support Barnsley)**

QUESTION 8

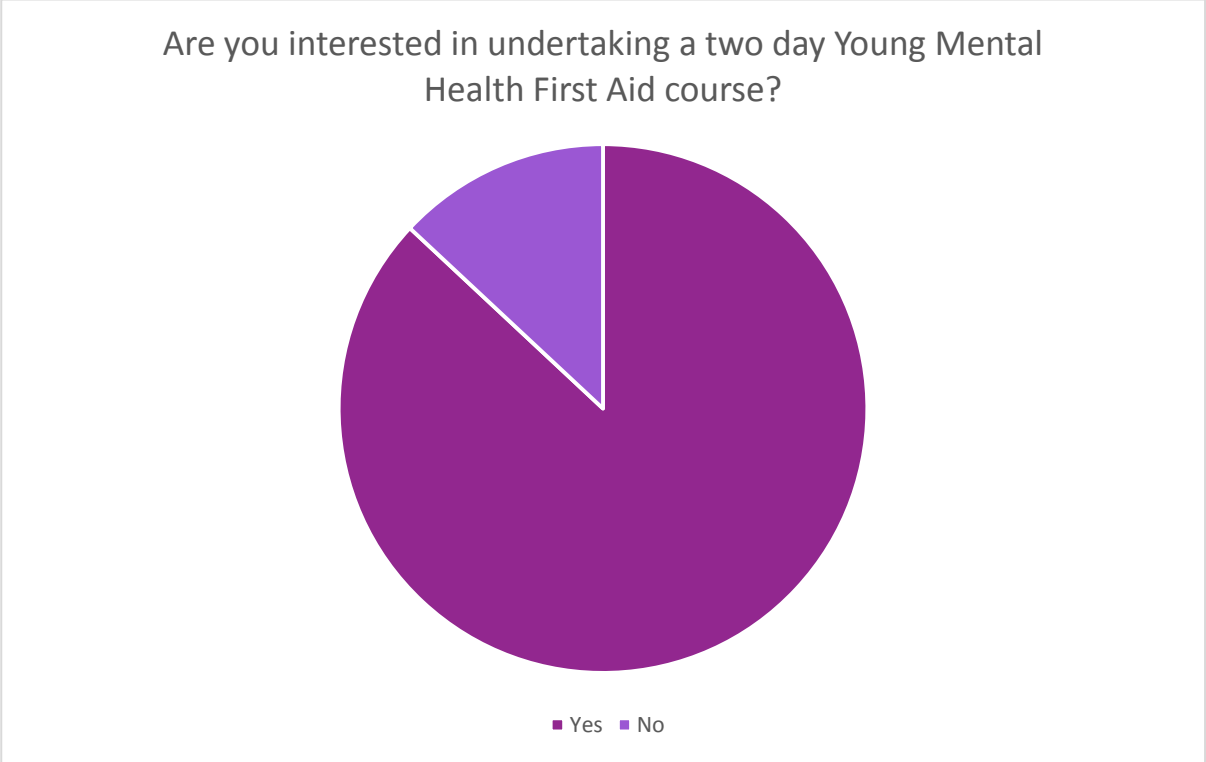
CHILYPEP is offering free training workshops to college staff around mental health and young people. What would you like to see included in this training? (Tick all relevant)



- 22 of the 39 respondents answered this question (56%)
- All but one of the respondents indicated they would be interested in more than one type of training
- **Self-harm Awareness** and **Signposting and Supporting Students** were the most popular choices, closely followed by **Challenging Stigma, An Introduction to Mental Health, In My Shoes** and **The 5 Ways to Wellbeing**.
- The respondent who indicated **Other** said: *"Eating disorders (this is a hugely common problem which is often a secret coping mechanism). I believe that it is often neglected because of this."*

QUESTION 9

Would you be interested in receiving the 2 day certified course, Youth Mental Health First Aid training, from CHILYPEP?



- 23 respondents answered this question (59%)
- The vast majority of respondents, 20, (87%) indicated that they were interested in the training, with only 3 (13%) indicating that this was not something they were interested in doing.

FEEDBACK FROM YMHFA TRAINING, 29TH-30TH JUNE

12 members of staff from Barnsley College underwent the Youth Mental Health First Aid Training on 29th and 30th June. Youth Mental Health First Aid is an internationally recognised coursed designed specifically for those people who teach, work, live with or care for young people aged 8-18. The course is split into four sections:

5. What is mental health?
6. Anxiety and depression
7. Suicide and psychosis
8. Self-harm and eating disorders

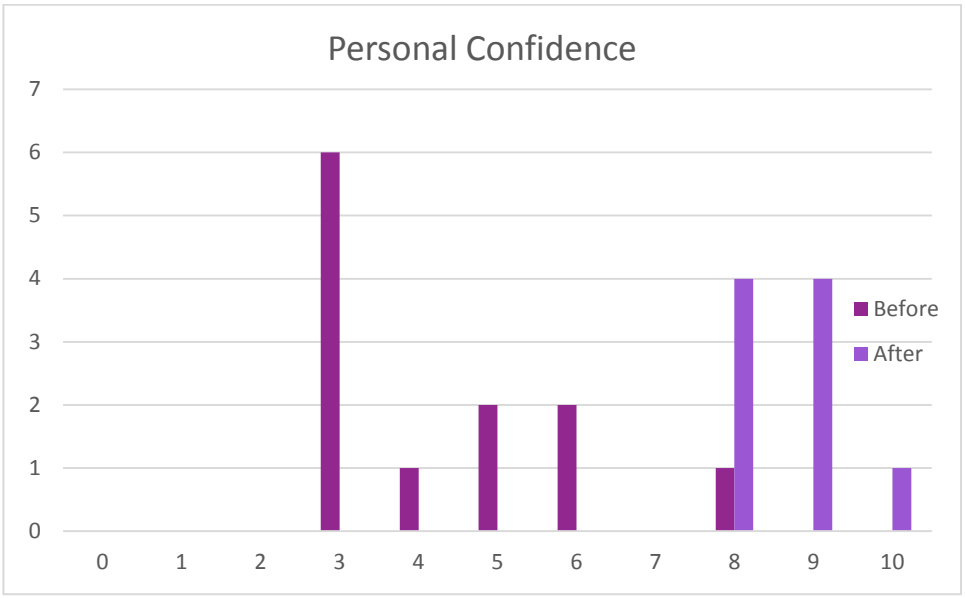
Within each section, participants learn how to:

- Spot the signs of a mental health problem in young people
- Feel confident helping a young person experiencing a problem
- Provide help on a first aid basis
- Help protect a young person who might be at risk of harm
- Help prevent a mental illness from getting worse
- Help a young person recover faster
- Guide a young person towards the right support

- Reduce the stigma of mental health problems

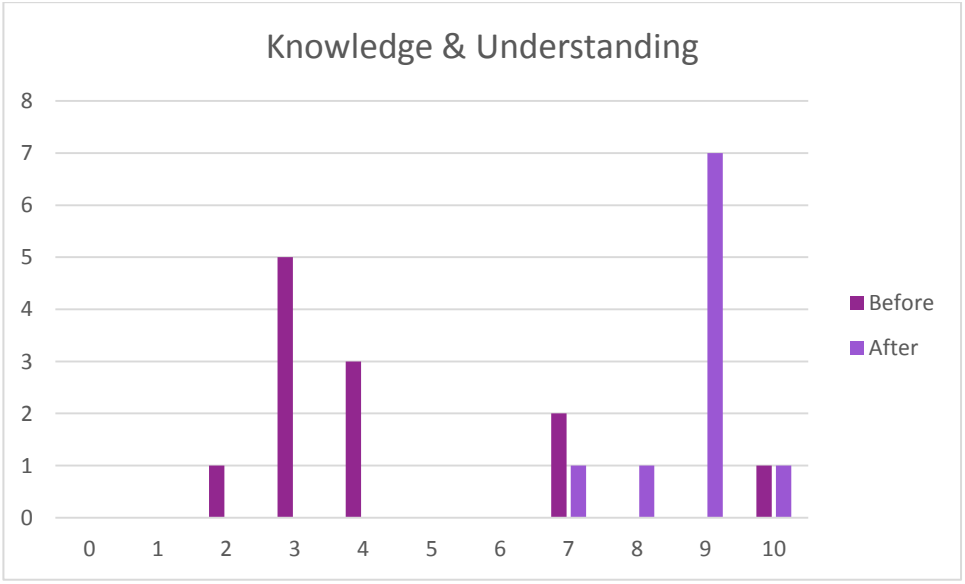
CONFIDENCE TO SUPPORT YOUNG PEOPLE – BASELINE DATA

Please score your personal confidence of how best to support young people with their mental health.



KNOWLEDGE AND UNDERSTANDING – BASELINE DATA

Please score your knowledge and understanding of how best to support young people around their mental health.



QUESTION 1

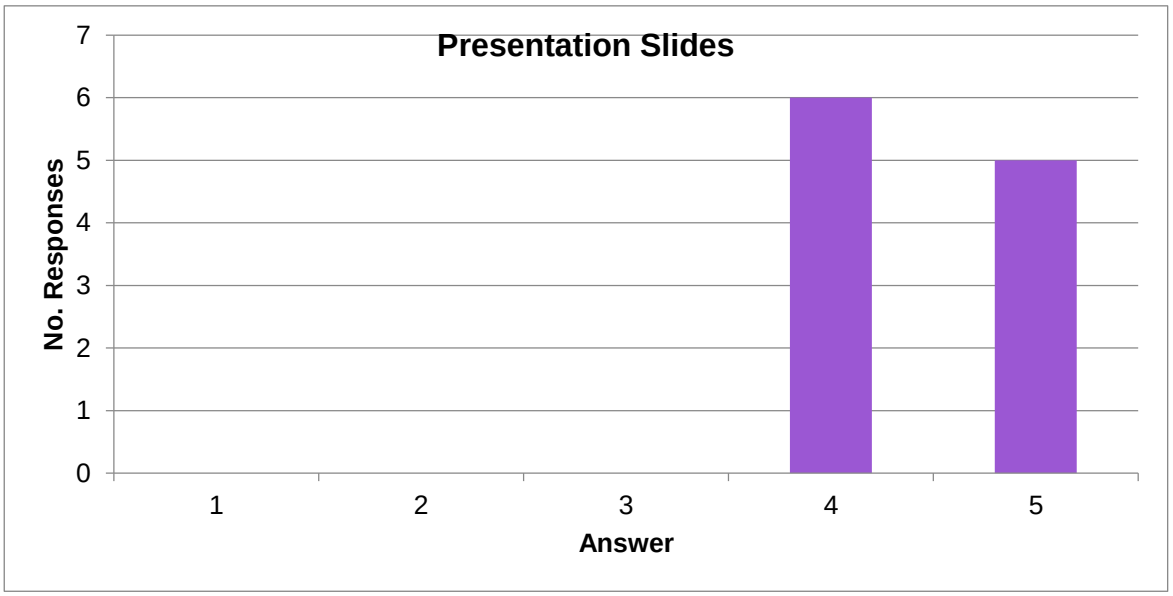
How would your rate the Instructors?

- 12 members of staff rated the instructors as ‘very good’

- “Both instructors were engaging, professional, listened and answered questions”.
- “Very confident. Informative.”
- “Excellent trainers. Knew slides inside out”.
- “Good, informative, flowed well.”

QUESTION 2

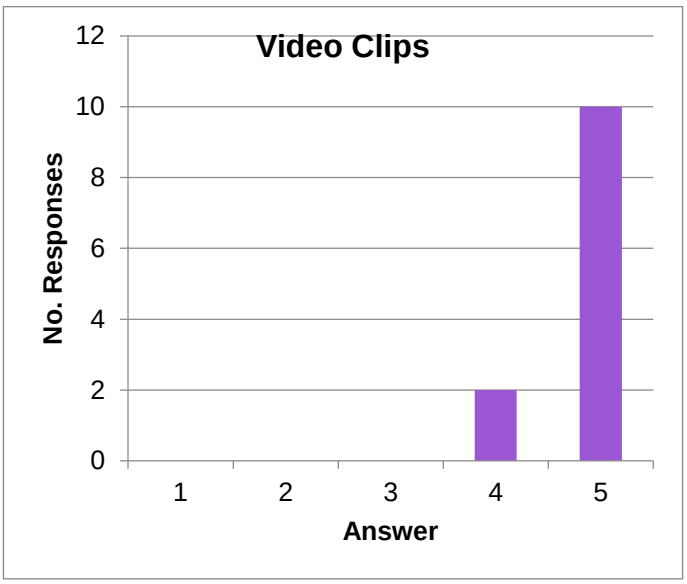
How would you rate the presentation slides?



- There were 11 responses to this question
- 6 members of staff rated the slides ‘good’, 5 rated them ‘very good’

QUESTION 3

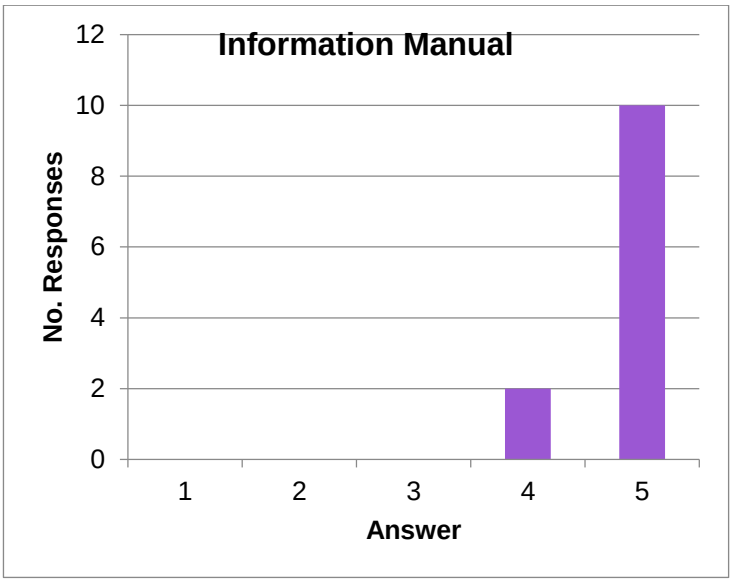
How would you rate the video clips?



- 10 staff members rated the video clips ‘very good’, 2 rated them ‘good’
- “Powerful, made the issues very real”

QUESTION 4

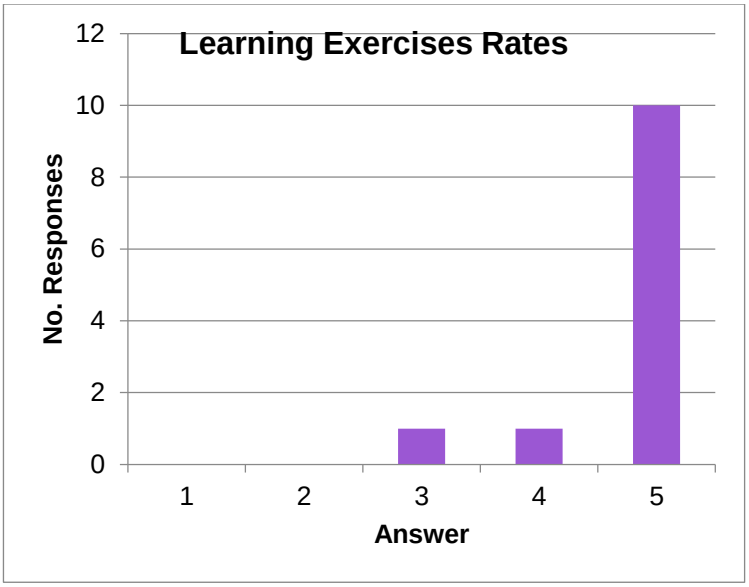
How would you rate the information manual?



- 10 participants rated the manual ‘very good’, 2 rated it as ‘good’
- “Loads of information, good to be able to take it here”

QUESTION 5

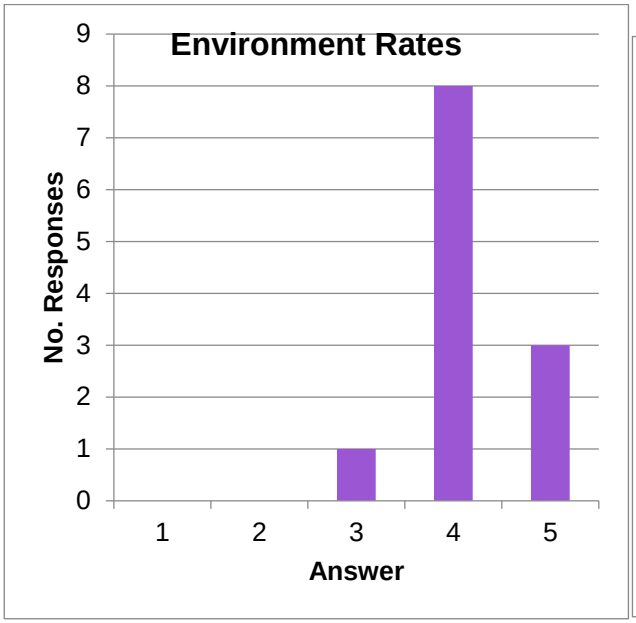
How would you rate the learning exercises?

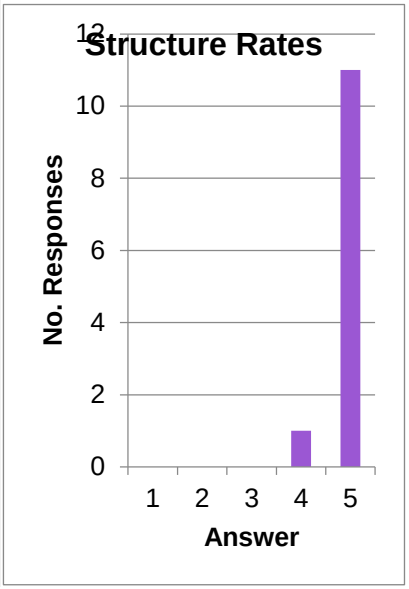


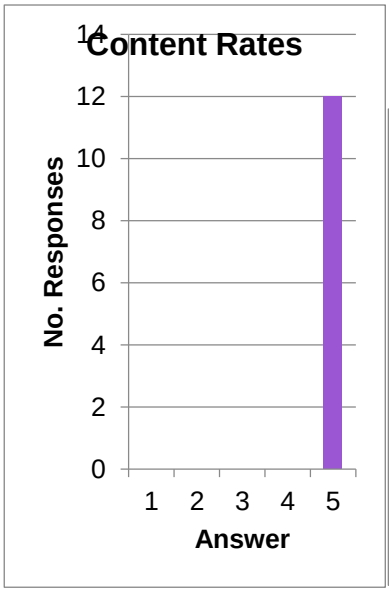
- “I enjoyed some of them, but others didn’t seem too helpful”

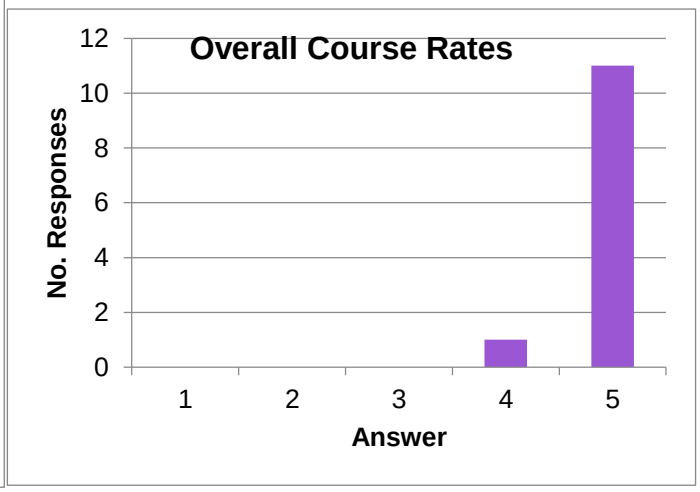
QUESTION 6

How would you rate the environment? Structure? Content? Overall course?









"Good on day one, not as good on day 2 as was a bit cramped"

"Really enjoyed the course. Lots of detailed information. Would recommend to other staff. Thanks"

"I put environment as I didn't like the rooms very much. Loved the active listening and hearing voices exercises. This has been really worthwhile. I have learnt so much."

"Both instructors were very helpful. I felt like I could ask them anything without being judged, no matter how silly some questions seemed. Knew everything what they was on about and overall very good training to do. I enjoyed it."

"Both instructors provided specialist information in different areas. E.g. substance misuse/ mental health. Adapted to the needs of the group. Haribos were a winner ☺"

"Very informative. Delivered very well by evidently informative staff/ instructors."

"The presentation allowed me to understand the definition and different ways of mental health."

"Very interesting trainers and excellent trainers who clearly knew their subject".

WRITTEN FEEDBACK ABOUT TUTORIALS DELIVERED BY CHILYPEP AT BARNSLEY COLLEGE

Below is a sample of written feedback from staff about the mental health tutorials delivered at Barnsley College by CHILYPEP and the Emotional Wellbeing Champions.

Outstanding, brave and inspirational presentations

The sessions … sound really interesting and extremely useful for students

This is absolutely fabulous

All staff agreed that it would be of great benefit to have a programme that ran over a few weeks so that learners could engage as the topic has a high prevalence within our department

The workshop was very active and engaging and a positive response was given by learners

We will welcome you in from September if that is possible

Just. Wow. Thanks very much to all of you! Keep up the amazing work!

The 'chilled out' and open environment makes [students] able to talk without fear of judgement.

i McManus s, Meltzer h, Brugha T et al. (2009) Adult Psychiatric Morbidity in England, 2007: Results of a household survey. leeds: nhs Information centre for health and social care.

ii Gavin n, Gaynes B, lohr k et al. (2005) Perinatal depression: a systematic review of prevalence and incidence. Obstetrics and Gynaecology 106: 1071–1083.

iii Kessler R and Wang P (2007) The descriptive epidemiology of commonly occurring mental disorders in the united states. Annual Review of Public Health 29: 115–129.

iv Hawton k, Rodham k, Evans E and Weatherall R (2002) deliberate self harm in adolescents: self report survey in schools in England. British Medical Journal 325: 1207–1211.

[v] Fergusson DM, Horwood LJ, Ridder EM. Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. J Child Psychol 2005; 46:937-49

[vi] Naylor C, Parsonage M, McDaid D, Knapp M, Fossy M, Galea A. Long term conditions and mental health – the cost of co-morbidities.The King's Fund and Centre for Mental Health. 2012.

[vii] Lieberman J, Stroups TS, McEvoy JP, Swartz MS *et al*. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med 2005;353(12): 1209-23.

Aged 11-25?

Want to have a real say in what services and support are out there for young people?!

Contact


chantelle.parke@chilypep.org.uk


Text/Call: 07896 131676


Facebook.com/Chilypep.


@Chilypep

www.chilypep.org.uk

Become a Young Commissioner!

Barnsley Clinical Commissioning Group

CHILYPEP
Children & Young People's Empowerment Project

Aged 11-25 and want to make a real difference and gain new skills?!

Become a Young Commissioner!

Chilypep is a charity that works to help young people get their **voices heard** to **make change** and we want young people to **have a say** in the services they want and need....

So, we are training young people as **"young commissioners"** - this means that you get to choose, alongside adults, which services should be funded, particularly around **mental health** and wellbeing!

You will get to take part in a **FREE training** programme, **rewards** for taking part, have something great to put on your **CV**, meet **new people**, gain **new skills**, **have FUN** and **make a difference!**

Important Dates

Make a DIFFERENCE!

Help improve services

Find out more about young commissioners!

- Wednesday 26th October 2016, 5-7pm venue to be confirmed

We will meet every two weeks from 5-7pm at a central venue:

- Wednesday 9th November
- Wednesday 23rd November
- Wednesday 7th December

Have your VOICE heard!

For more information and to get involved contact:

Email: chantelle.parke@chilypep.org.uk

Text/Call: 07896 131676

Have FUN!!!

Gain new skills!

Meet new people!

NHS Barnsley Clinical Commissioning Group

CHILYPEP Children & Young People's Empowerment Project

South West Yorkshire Partnership NHS
NHS Foundation Trust

Barnsley, Wakefield, Calderdale and Kirklees Community Eating Disorder Service: Implementation Plan progress report.

Dave Ramsay: Deputy Director of Operations

Claire Strachan: General Manager Barnsley CAMHS

August 2016

www.southwestyorkshire.nhs.uk

With all of us in mind.

1. Purpose

1.1
This paper outlines South West Yorkshire Partnership Foundation Trust's (SWYFT) implementation plan for establishing a community eating disorder service for children and young people across the districts of Barnsley, Calderdale, Kirklees and Wakefield.

1.2
As agreed following submission of the initial service proposal (January 2016 paper)[1] this paper provides an update by means of an implementation plan and progress against key milestones to include further detail with respect to staff recruitment, pathway development and performance metrics. It also offers additional financial detail, specifically in relation to 2015/16 start up costs.

As requested it also provides an outline of the service model and variation from the National Specification and an illustration of how the crisis element of the funding is provided and the interface with specialist CAMHS in this regard. It is further demonstrated how the SPA function and duty / crisis response in the specialist CAMHS service general offer is integral to the delivery of the Eating Disorder service.

2. Service Model

2.1
The proposed service model is broadly equivalent to that defined in the *Access and Waiting Time Standard for Children with an Eating Disorder*[2] as '*Model B - a team that operates via a network of smaller teams of eating disorder clinicians in neighbouring areas, via a hub and spoke model'*.
It builds on existing eating disorder pathways and multi-disciplinary team arrangements within the three local teams/areas (Barnsley, Calderdale/Kirklees and Wakefield) and will be integrated within the generic Child and Adolescent Mental Health Service (CAMHS) management arrangements. The 'hub' will comprise a Consultant Psychiatrist and the Eating Disorder pathway leads (specialist clinicians) from each local team alongside the CAMHS Clinical Lead and Practice Governance Coaches. The 'hub' will perform an important professional leadership and learning network role across the full service thus ensuring robust and consistent approaches to staff development and quality assurance. However, the initial focus is on strengthening the local resource bases and pathways, investing in increasing the capacity and skills set of the current multi-disciplinary teams.

2.2
As described in the proposal paper the core service elements will include;

Specialist assessment and therapy/treatment: founded on NICE guidance Eating disorders in over 8s: management (CG9)[3] and with an identified care coordinator.

Physical health assessment and support: through close liaison with paediatricians and robust shared care protocols with GP's.

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[1] D Ramsay (2016) Proposal Barnsley, Calderdale, Kirklees and Wakefield Community eating Disorder Service

[2] National Collaborating Centre for Mental Health (2015) *Access and Waiting Time Standard* for Children with an Eating Disorder available at : https://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf

[3] NICE Eating disorders in over 8s: management available at : https://www.nice.org.uk/guidance/cg9

Dietetic support: including nutritional rehabilitation planning

Education and training: targeting primary care, education and social care professionals.

Crisis and Intensive Home-Based Treatment: 24/7 access to emergency assessment (typically in A&E departments and paediatric wards) and subsequent short-term intensive support.

2.3
The agreed pathway is illustrated at Appendix 1. Referral to the eating disorder pathway will be via existing local single point of access (SPA) arrangements for CAMHS. A move to e-based and self-referral will be managed as part of ongoing developments in SPA commissioning and functionality. Following referral direct contact will be made with the child/young person and/or parent/carer to clarify presenting risk/urgency in accordance with national standards (Appendix 1). Treatment will commence within 1 week (7 days including weekends) for all emergency/urgent cases with a care plan and identified care coordinator. For routine cases treatment will be received within a maximum of 4 weeks (28 days including weekends) from first contact. The clock will start in this regard when the request for an eating disorder assessment is received by SPA as the primary reason for referral and / or this is recognised as such and recorded, regardless of the agency making the request.
Where it is an emergency case initial contact will be made within 24 hours and a comprehensive assessment will take place within 1 working day. This first contact for support may be provided by the Generic CAMHS duty / crisis team or the Out of Hours service. Out of Hours the clock will start when the referral is received and an eating disorder is recognised as the reason.

2.4
Children, young people and their families must understand how to ask for help and all those working with children and young people with mental health problems must know how to recognise eating disorders and how to access appropriate care when needed. On this basis the implementation plan will include a proactive approach to relationship-building with key service stakeholders and service promotion. Particular attention will be paid to promotional work with potential referrers (GP's and schools) and children/young people and their families. This work will include a strengthened digital communication platform.

2.5
Robust systems of staff recruitment and retention will be maintained and will complement a service focus on ongoing professional development and staff supervision. A learning network will be created across the locality eating disorder services ensuring routine service audit/evaluation/benchmarking (and associated action planning) and exploring opportunities for involvement in research etc. Professional development will be further supported through involvement in the Children and Young Peoples Improving Access to Psychological Therapies (CYP-IAPT) programme. In addition, we will commit to participating in the national quality improvement network (as established by CCQI) - seeking relevant accreditation(s) as/when the necessary frameworks are developed by CCQI.

3. Performance Monitoring

3.1
Data collection/reporting templates will be established to meet the specified requirements of the *Access and Waiting Time Standard* (*Table 10: Outcome Measures)* with all items mapped to MHSDS. PROMs and PREMs data will be collected at relevant stages of the care pathway with routine use of the Eating Disorder Examination Questionnaire (EDE-Q) version 6.0. The metrics below are proposed as a starting point for contract performance monitoring and ongoing service improvement. Monthly reports will be made available to commissioners (and separated by CCG) outlining the monthly and cumulative (year to date) position. The relevant data was planned for collection from 1 April 2016 with the first report made available to commissioners in May 2016 however the development and validation of the data packs has been delayed. It is expected that reporting will commence from August 2016 and be presented to commissioners in September 2016.

Future data will be presented in the usual graph format from the Trust Performance and Information Team.

Section 3.3 below presents in table format the manual data collected by the service to provide reasonable assurance that progress is being made with regard to data capture and validation for the purpose of this paper.

Figure 1:

Indicator	Target
Number of referrals (emergency/urgent/routine)	
Number of referrals by source	
% emergency referrals contacted within 24 hours	100%
% urgent referrals commenced treatment within 5 days	100%
% routine referrals commenced treatment within 4 weeks	100%
Number of discharges	
Number of open cases at end of the period	
Number of ED referrals to Tier 4	
Number of ED transitions to adult mental health services	
% cases with at least two completed EDE-Q (6.0)	100%

Note: the definitions for clock start/stops defined in *Guidance for Reporting Against Access and Waiting Time Standards*[4] will be used for reporting purposes.

3.2

It must be noted that the ability of services to meet the access targets specified in the *Access and Waiting Time Standard for Children and Young People with an Eating Disorder* (NHSE, July 2015) guidance will be monitored at a national level in 2016. It is anticipated that the standard will be refined for implementation from 2017–18 with data collected in 2016 informing trajectories for incremental percentage increases, with the aim of setting a 95% tolerance level by 2020. Data will also be reported consistent with the revised MHSDS arrangements - with CAMHS (and eating disorder service) data returned to the HSCIC.

3.3

The implementation timetable at section 5 identifies a phased process of local service development the initial proposal offered assurance that access targets for emergency, urgent and routine referrals would be consistently met from 1 April 2016 i.e. 95%+.

Manual Data provided by services related to the number of referrals and performance against the national access times standards is provided below. In order to meet the access target criteria, a referral must have a referral reason of "eating disorder"; the clock will stop once treatment has commenced (use of treatment activity codes as supplied nationally).

The manual data has been reviewed on a case by case basis as treatment activity codes have not always been consistently used and a case summary has been provided for assurance / exception reporting purposes.

The clock starts at the date of referral when the primary reason for referral is suspected Eating Disorder or where this is identified at triage. Where Eating Disorder is not suspected at triage the clock starts when suspicion is first raised. The clock stops when NICE approved treatment starts or waiting time ends for non-treatment when a clinical decision is reached not to treat as an Eating Disorder.[4]

[4] NHSE (2016) *Guidance for reporting against access and waiting time standards: Children and Young people with an Eating Disorder. Available at : https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf*

The lessons learned from the cases that have breached the access target will be shared at the clinical network meeting to inform any actions required both locally and hub wide.

Commissioners requested a sample of cases scenarios however due to timescales the families have not been approached for consent and therefore a single high level case summary of a referral in August has been presented in section 3.5 alongside outline case summaries within the data tables below.

Barnsley: As at 31st July 2016 open cases on the ED pathway was 21.

Month	Referral numbers	Type	Access target met	Case Summary
April 2016	2	1 x urgent	No	Referral received 14.04 16 via SPA and passed to generic urgent initial assessment. Seen 25.04.16 and concerns about ED confirmed and seen 29.04.16 by ED staff. Did not meet target as went to generic urgent assessment not into ED assessment. Not into treatment for 15 days and correct intervention stop clock coding not used.
		1 x routine	No	Referral 28.04.16 SPA triaged as Anxiety. Seen for initial assessment on 19.05.16 where suspicion re ED raised although no concerns re W4H. Routine clock start as of this date and seen on 05.07.16 therefore not into treatment for 37 days.
May 2016	0			
June 2016	0			
July 2016	0			

NB: Week commencing 1st August 2016 3 referrals received of which 1 was urgent and 2 were routine.

Wakefield: As at 31st July 2016 open cases on the ED pathway was 14

Month	Referral numbers	Type	Access target met	Case summary
April 2016	3	3 x routine	No	Referred 13.01.16. Eating issues noted but not triaged as ED. Initial assessment 03.03.16 where ED should have been suspected *(clock start)* and not discussed with ED team until 11.04.16 and then seen 27.04.16 = 55 days into treatment.
			No	Referred 21.04.15. Waiting for therapy and concerns raised re potential ED by agency on 12.02.16 (clock start) and seen 21.04.16 for generic assessment and ED team consulted and saw 25.05.16 decision to discharge and not treat for ED = treatment wait clock stop 61 days
			No	Referred 04.03.16 and ED suspected 18.04.16 (clock start) and ED Initial treatment appointment 11.05.16 cancelled by client and seen 19.05.16 = 31 days into treatment
May 2016	1	1 x routine	No	Referred 07.03.16 and ED suspected 22.04.16 (clock start) and ED team notified 11.05.16 with appointment for 31.05.16 not attended. ED team liaison with family on 31.05.16 and decision not to treat therefore clock stopped = 42 days.
June 2016	1	1 x urgent	Yes	Referred 03.05.16 and ED suspected 07.06.16 and seen 13.06.16 = 6days
July 2016	0	1 x urgent	No	Referred 13.07.16 and SPA attempts to secure height and weight from referrer delayed for 5 days and ED team advised urgent on 18.07.16. Seen on 21.07.16 by ED team = 8 days into treatment.

NB: Week commencing 1st August 2016 1 referral received of which was urgent

Calderdale and Kirklees: As at 31st July 2016 open cases on the ED pathway were 68 cases of which 23 are within Calderdale and 45 within Kirklees.

Month	Referral numbers	Type	Access target met	Case Summary
April 2016	5 referrals (2 Kirklees) (3 Calderdale)	1 x urgent 4 x routine	Yes	Referred 23.03.16 (routine clock start) and triage for routine ED. Decision not to progress as ED 05.04.16 treatment wait clock stop at 12 days.
			No	Referred 09.02.16? ED issues noted. New referral from GP 08.04.16 ED (urgent clock start) appointment offered 11.04.16 client DNA and failed contacts by service discussed on 03.05.16 and GP advised re non engagement 25.05.16 and tests requested seen 02.06.16 = 55 days.
			Yes	Referred 16.03.16? ED issues noted. 29.03.16 ED suspected (routine clock start) seen 26.04.16 = 28 days
			Yes	Referred 19.04.16 which was redirected to CAMHS 25.04.16 and primary referral reason not ED although issues noted. Initial assessment 18.05.16 ED suspected (clock start routine) and decision not to treat as ED 31.05.16 (treatment wait clock stop) = 13 days
			Yes	Referred 14.12.15 with other primary reason suspicion re ED raised 19.04.16 (routine clock start) and treatment started 10.05.16 = 21 days
May 2016	7 referrals (4 Kirklees) (3 Calderdale)	3 x urgent 4 x routine	No	Referred 03.05.16 (routine clock start). GP contacted for information re weight for height (W4) and again on 17.05.16 and secured on 20.06.16 and in normal limits information re ED presentation requested from GP which was not secured therefore decision not to treat and discharged 22.07.16 = treatment wait stop clock at 80 days.
			No	Referred 14.04.16 (routine clock start) appointment 09.06.16 cancelled by family and decision not to treat after assessment on 12.07.16 = treatment wait stop clock at 89 days
			Yes	Referred 04.05.16 (urgent clock start) and treatment started 06.05.16 = 2 days

			Yes	Referred 03.05.16. ED suspected at Initial assessment on 11.05.16 (routine clock start) GP tests requested and decision not to treat 08.06.16 = treatment wait clock stop at 28 days
			No	Referred 13.05.16 (urgent clock start) assessed by crisis team 19.05.16 and passed to ED team therefore treatment not started. ED team 25.05.16 (clock stop) = 12 days
			Yes	Referred 13.05.16 (routine clock start) and seen by ED team 01.06.16 = 18 days
			No	Referred 12.05.16 (urgent clock start) ED initial contact 20.05.16 = 8 days
June 2016	6 referrals (4 Kirklees) (2 Calderdale	2 x urgent 4 x routine	No	Referred 08.06.16 (routine clock start) and had contact with crisis team to assess risk on 15.06.16 seen by ED team 13.07.16 (clock stop) =35 days
			Yes	Referred 11 .06.16. Suspicion re ED raised 15.06.16 (routine clock start) into treatment (CBT self-help 28.06.16 (clock stop) = 13 days
			No	Referred 20.06.16 (routine clock start). Family unable to attend appointments and seen by ED team 25.07.16 (clock stop) =35 days
			Yes	Referred 24.06.16 (urgent clock start) and seen and treatment started 27.06.16 (clock stop) =3 days
			Yes	Referred 28.06.16 (urgent clock start) and into treatment 01.06.16 (clock stop) = 3 days. **Case monitored by school nursing and a case review would be beneficial re delay to escalate to CAMHS ED.
			Yes	In service and Re-emergence of previous ED symptoms noted 28.06.16 (routine clock start) ED treatment started 13.07.16 (clock stop) = 15 days
July 2016	5 referrals (5 Kirklees).	Data in report provided by and informatics		

3.4
Learning from data review

A cross service discussion / peer review of sample cases to be discussed at the clinical hub to establish and provide assurance regarding:

- Consistent use of clinical activity codes to inform clock start / stops
- Application of consistent criteria for Eating Disorder
- Timely recording when a clinical decision is reached not to treat cases for Eating Disorder
- Prompt liaison with GP to determine physical observations to ensure access times are met (Note: the referral to discharge pathway [Appendix 1] was updated in July and the use of the updated screening tool [Appendix 3] was also promoted in July).
- What education and support should be provided to universal and 'Tier2' services to facilitate early intervention

**** Calderdale and Kirklees:** Consideration should be given by the ED hub as to the benefits of seeking consent for a case review for the urgent case referred 28.06.16. The focus is with regard to what education and support should be provided to universal and 'Tier2' services to facilitate early intervention and facilitate consultation / referral to CAMHS in a timely manner.

3.5
Case Study

Child X was open to the service and during an appointment on 3 August 2016 concerns were raised regarding suspicion of Eating Disorder and a referral to the Eating Disorder pathway was made on the same day (urgent clock start). Family had identified physical health concerns and triage by SPA took place using the ED Screening tool (Appendix 3) on 4 August 2016. The GP was contacted on 4 August 2016 at 1pm. The family were asked to contact GP to attend an urgent appointment to record weight and height, sitting and standing BP, temperature, and bloods tests. A home visit and full eating disorder assessment was completed 5 August where treatment started with guided self-help and W4H body percentage was noted as 75.27% (treatment clock stop at 2 days). An ECG was booked and an appointment with a Consultant Psychiatrist took place on 9 August 2016 and a referral to dietician was made on 10 August 2016.

Based on learning from cases breached and the use of activity codes the team used the Screening tool and met all access times and the child entered treatment in a timely manner. However correct codes for activity are still not recorded and will be addressed as part of the learning.

4. Finance and Staffing

4.1
The proposed service budget and staffing establishment is outlined below in Figure 2 with an updated position as at July 2016 provided in Figure 3:

Figure 2:

	Barnsley		**Calderdale/ Kirklees**		**Wakefield**		**Total**	
	wte	£	wte	£	wte	£	wte	£
Psychiatrist	0.1	11486	0.0	0	0.0	0	0.1	11486
Band 7 Lead	0.6	29060	1.0	56146	0.8	44917	2.4	130123
Band 6 Therapist	1.0	40394	2.0	80788	1.4	56552	4.4	177734
Band 6 Dietician	0.2	8079	0.4	16158	0.0	0	0.6	24236
Band 6 MHP (Crisis)	1.0	40394	2.0	80788	1.0	40394	4.0	161576
Band 4 Support	0.0	0	1.5	40002	1.0	26668	2.5	66670
Band 4 Admin	0.0	0	0.5	13334	0.0	0	0.5	13334
Estate		0		0		0		0
Travel		5600		10800		6400		22800
Agile Equipment		1300		2500		1600		5400
Other non-pay		580		1480		840		2900
Sub totals	**2.9**	**136892**	**7.4**	**301996**	**4.2**	**177370**	**14.5**	**616258**
Indirect costs & overheads		9487		22341		18145		49973
TOTAL RECURRENT COST		**146379**		**324337**		**195515**		**666231**
2015/16 set up								
Training (including backfill)		36275		8300				44575
Medical staffing		3000		3000		3000		9000
Nursing staffing (incl. agency)		78054		38339		33928		150321
Therapy staffing (incl. agency)		4652		20781		4652		30085
Admin and data management		2760		2760		2760		8280
Resources		12506						12506
Management costs		9132		8820		4410		22362
2015/16 SET UP COSTS TOTAL		**146379**		**82000**		**48750**		**277129**

Figure 3: Barnsley recruitment update

Barnsley					
Proposed structure			**Actual structure as July 2016**		
	wte	**£**		**wte**	**Service update**
Psychiatrist	0.1	11,486	Psychiatrist	0.2	In post and identified lead for Barnsley and attends hub meetings and alongside staff grade psychiatry sessions to the ED pathway medical review averages an additional 0.1 wte.
Band 7 Lead	0.6	29,060	Band 7 Lead	0.6	Agency Cognitive Behavioural Therapist in post since April pending substantive recruitment
Band 6 Therapist	1.0	40,394	Band 6 Therapist	1.0	Additional Recruitment to 1 wte Band 6 post in crisis / outreach service since April 2016. This provides care coordination across the team. Further Band 6 recruitment undertaken and offer to dedicated Eating Disorder Band 6 clinician to be made by 8th August.
Band 6 etician	0.2	8,079	Band 6 Dietician	0.2	Provided from Trust wide dietic service
nd 6 HP risis)	1.0	40,394	Band 6 MHP (Crisis)	1.0	Additional Recruitment to 1 wte Band 6 post in crisis / outreach service since April 2016. Provision of daily advice to SPA and direct contact with families to establish urgency. Provision of emergency ED assessment in hours (M- F :9-5)
			Band 8a Nurse Specialist	0.3	Currently released from the generic service to attend the hub meetings and coordinate the Eating Disorder pathway to ensure robust implementation pending recruitment to the Band 7 lead post. This Nurse also holds a caseload of Eating Disorder cases.
			Dedicated Admin	Daily	Released from the generic service to support the MDT and SPA functions
			SPA function	Daily	Integral component of generic service to ensure
			Out of Hours (OoH)	Daily	Integral component of service to ensure access to OoH assessment provided from generic service
			Line management and clinical supervision	Daily	Integral component of service provided from generic service
			Note: The service is reviewing job plans for the generic service and exploring the options for provision of Band 3 Health Care Assistant time to the ED pathway from the generic team.		

Figure 4: Wakefield recruitment update

Wakefield					
Proposed structure			**Actual structure as July 2016**		
	wte	**£**		**Wte**	**Service update**
Psychiatrist	0.0	0	Psychiatrist	0.2	Psychiatry time is job planned and this consultant attends the clinical network hub meetings and takes a lead role at the clinical network hub.
Band 7 Lead	0.8	44917	Band 7 Lead	1	A substantive band 7 senior mental health practitioner is in post and attends the clinical network hub meetings
Band 6 Therapist	1.4	56552	Band 7 Therapist	1	The service has recruited 1 wte Band 7 Cognitive Behavioural Therapist and attends the clinical network hub meetings
Band 6 MHP (Crisis)	1.0	40394		Daily	Provided by current crisis and Intensive home based treatment team
Band 4 Support	1.0	26668	Band 3 Support	1	The service is recruiting 1 wte Band 3 Health Care assistant to support the ED service and crisis team
nd 4 min	0.0	0			
			Band 8a family Therapist	0.6	A substantive family therapist is in post and attends the clinical network hub meetings
			Admin	As required	Released from the generic service to support the MDT. Admin function under financial review.
			SPA function	Daily	Integral component of generic service
			Out of Hours (OoH)	Daily	Integral component of service to ensure access to OoH assessment provided from generic service
			Line management and clinical supervision	Daily	Integral component of service provided from generic service and ED pathway lead.

Figure 5: Calderdale and Kirklees recruitment update

Calderdale and Kirklees					
Proposed structure			**Actual structure as July 2016**		
	wte	**£**		**Wte**	**Service update**
Psychiatrist	0.0	0	Psychiatrist	Daily	Crisis team psychiatrist covers as required no dedicated provision
Band 7 Lead	1.0	56146	Band 7 senior mental health practitioners	2.4	1.4 wte Band 7 are in post.
					1 wte Band 7 senior mental health practitioners was in post until July and was re- recruited to in August. Cover is currently provided by agency staffing.
Band 6 Therapist	2.0	80788	Band 7 family therapist and psychologist / counselling psychologist	1.6	Band 7 0.6 wte family therapist is out to advert and 1wte psychologist is currently out to advert and cover is currently provided by agency staffing for both posts.
nd 6 etician	0.4	16158	Band 6 Dietician	0.6	Provided from Trust wide dietic service and out to recruitment was in post until July 2016
nd 6 MHP risis)	2.0	80788	Band 6 MHP (Crisis)	Daily	Provided by current crisis and Intensive home based treatment team
nd 4 Support	1.5	40002	Band 3 Support	1.2	0.6 wte Band 3 Health Care assistant in post and 0.6 out to advert
Band 4 Admin	0.5	13334	Band 3 Admin	0.6	0.6 wte Band 3 is currently out to advert
			Band 8a Psychologist pathway lead	0.6	A substantive psychologist is the pathway lead in post and attends the clinical network hub meetings
			Out of Hours (OoH)	Daily	Integral component of service to ensure access to OoH assessment provided from generic service
			Line management and clinical supervision	0.4	Integral component of service and provided from the crisis team manager

5: Implementation Timetable

An outline implementation plan is attached at Appendix 2. Progress against the plan will be closely monitored and reported through the monthly contract management meetings. A summary against each of the overarching themes of the implementation is provided below.

Recruitment:

- Recruitment has been undertaken and the current position is illustrated in Figures 3 , 4 and 5 above

Professional Development:

- A multi-disciplinary clinical learning network has been established and meets monthly and operates as the hub. Nominated staff from each locality attend the meeting and share learning and develop shared protocols.

- Local services have an understanding of the skills of staff however a robust training needs analysis is to be undertaken once all newly recruited staff are in post. The service is currently awaiting a cost for a CAMHS wide team profile using The Self Assessed Skills Audit Tool (SASAT)[5]. This cross locality information will enable the service to commission appropriate training for both existing and new staff and build sustainability (including via supervision) across services.

- The requests for CYP-IAPT training have been submitted to the regional collaborative meeting and the services are awaiting a decision regarding the allocation of places. Places have been requested for Evidence Based Psychological Therapies for Children & Young People in: Cognitive Behaviour Therapy, Systemic Family Practice – Eating Disorder, Interpersonal Therapy for Adolescents with Depression and also the shorter Enhanced Evidence Based Practice Programme for Children and Young People. Supervisory places for the therapies have also been requested.

- It is noted that NICE guidance for the treatment of Eating Disorder recommends adapted forms of CBT which include CBT – E and CBT – BN. The Wakefield service has a CBT therapist who has accessed CBT –E training and as part of the Training Needs Analysis the service will establish which staff may be eligible for extended training and the financial costs.

Pathway development and promotion

- The Wakefield service has developed an Eating Disorder pathway which is being finalised prior to final approval. Localised versions are under development for the spoke teams.

[5] National CAMHS Workforce Programme, National CAMHS Support Service (NCSS) (2010)SASAT tool http://www.chimat.org.uk/resource/item.aspx?RID=103044

- The overarching pathway flowchart has been discussed at the August hub meeting and has been revised to include Routine Outcome Monitoring (Appendix 1)

- The Clinical Nurse Lead from the Barnsley service has further developed an existing CAMHS Triage and assessment form that is currently being piloted (Appendix 3). This form includes more detailed guidance for the SPA team on the expectations and timescale for liaison with families in line with the national access times[2.]

- The DNA process has been discussed at the clinical meeting and the services are working to the Trust policy and undertaking

- Standardised GP letters that give clear treatment direction are being developed and shared across the services

- The service is currently discussing CCQI / QNCC membership to enable the ED service to access the benefits of service evaluation / peer review and n accreditation

- The Trust is finalising the systems and processes for introducing a text reminder service and this is anticipated to be available for consenting families in September 2016

- The services will also be considering options to develop self-referral and education to universal services with Barnsley giving consideration for developing a pilot using the SCOFF Questionnaire for ED amongst primary care staff to inform referral / SPA triage. [6]

Service monitoring and evaluation

- The multi-disciplinary clinical learning network has agreed to share suggestions for resources and self-help guides for discussion at the September meeting to promote consistency across the services. Once agreed the services will review how these resources can be promoted on the Trust website.

- The service has yet to review and develop paediatric liaison protocols and this will be an agenda item for the September meeting.

- The data packs are in the process of being built and tested so services do not have any validated automated data available at the time of writing this report. It is anticipated that the automated reports will be tested during August and all teams are working with the Trust Performance and Information department to review data to enable the monthly reporting to commence. It is expected that automated reporting will be available from late August .Subsequent evaluation of service outcome data (including FFT) will follow.

[6] Kings College London (undated) SCOFF Questionnaire. Available at: http://cedd.org.au/wordpress/wp-content/uploads/2015/04/SCOFF-Questionnaire.pdf

Meeting the access standards

- All teams have been issued with the necessary information regarding the access standards and this has been discussed at the multi-disciplinary clinical learning network

6: Service model variation from the National Specification for Hub and Spoke services

- The model requires an organisational chart to ensure the structure and overall leadership is clearly defined. The General Manager (Barnsley CAMHS and Consultant Psychiatrist Wakefield have been identified to lead the implementation)

- Not all services have staff who can offer the full range of psychological interventions for Eating Disorder e.g. CBT –E, CBT-BN, Cognitive Analytic Therapy (CAT), Interpersonal therapy, focal psychodynamic therapy and Family Therapy.

- The service is not delivering a systematic training programme to raise awareness of eating disorders amongst universal services and this will need to be agreed as part of the service offer and Local Transformation Plans

- The service is not systematically involving young people and families in all aspects of the service design. A workshop event is planned for 30th September hosted by Eva Musby which will bring together staff and parents [7]

- The service has yet to confirm its decision regarding which national quality improvement and accreditation network it will progress membership. Currently existing QNCC members.

- The service has yet to receive confirmation regarding which CYP-IAPT courses are on offer to the partnership sites for 2016 / 17.

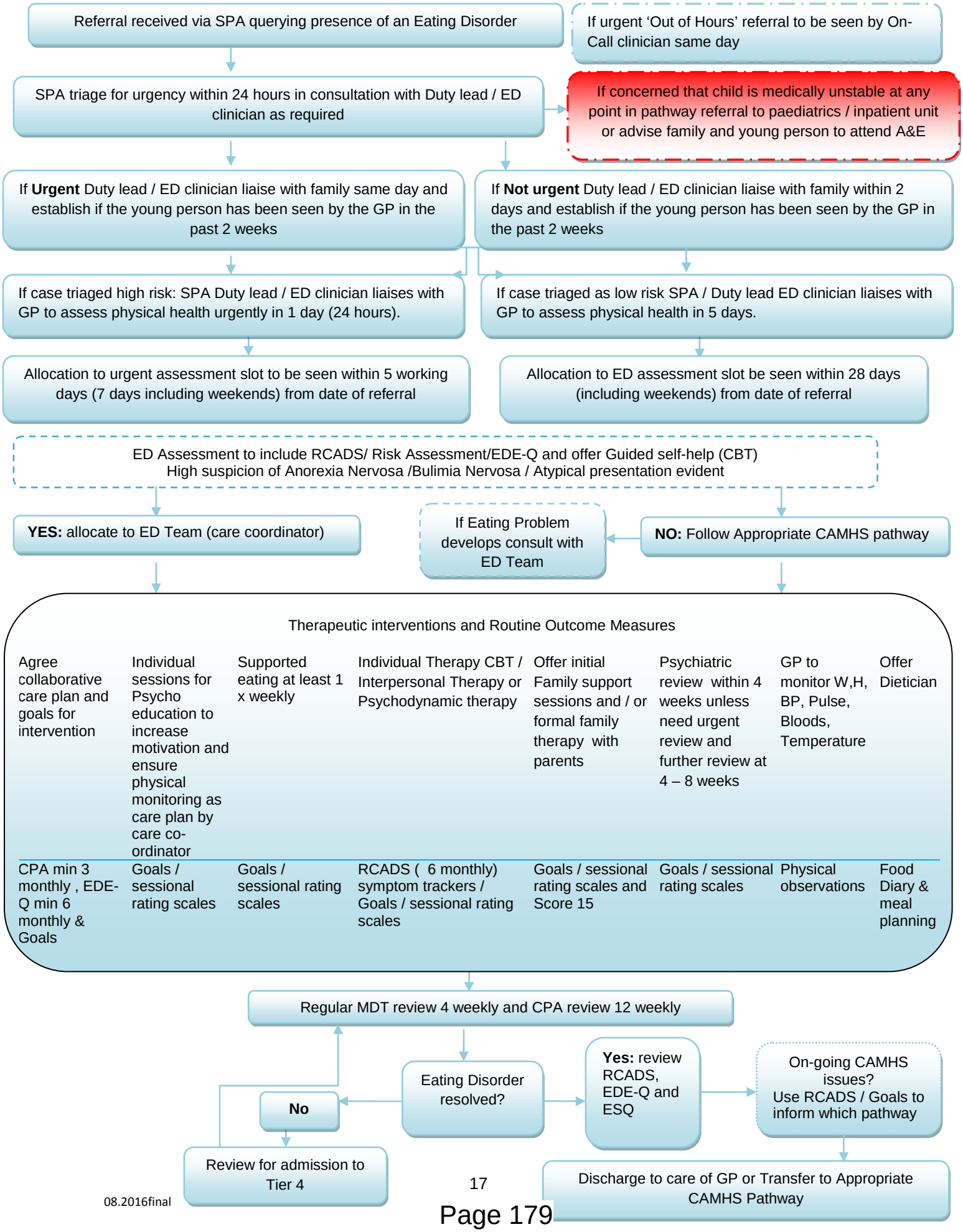
- The data is not validated regarding referral rates to inform robust staffing ratio evaluation as per workforce calendar by population and referral numbers.
  There is not dedicated psychiatry time in all localities.

- Robust protocols between GP's and Paediatric services are yet to be developed and tested.

- Extended opening hours are not yet available.

[7] Website undated 'Anorexia and other eating disorders : how to help your child eat well and be well http://evamusby.co.uk/events/

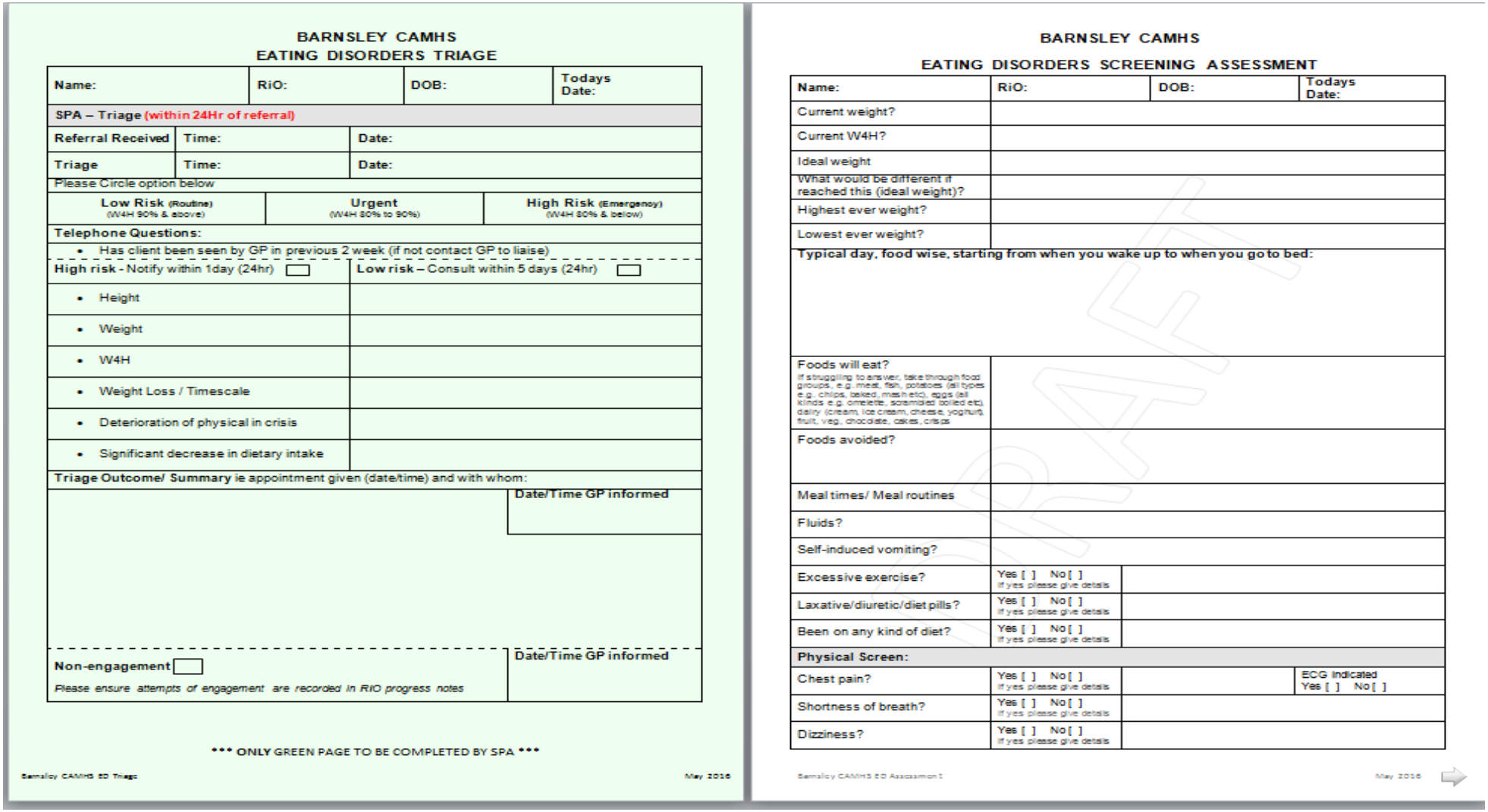
Appendix 1: Referral to discharge pathway where an Eating Disorder is suspected



Appendix 2: Implementation plan

camhsedimplementationappx2.xlsx

APPENDIX 3: Barnsley Eating Disorder Triage Profroma (Page 1 and 2)



BARNSLEY CAMHS
EATING DISORDERS TRIAGE

Name:	RiO:	DOB:	Todays Date:

SPA – Triage (within 24Hr of referral)

Referral Received	**Time:**	**Date:**
Triage	**Time:**	**Date:**

Please Circle option below

Low Risk (Routine) (W4H 90% & above)	Urgent (W4H 80% to 90%)	High Risk (Emergency) (W4H 80% & below)

Telephone Questions:

- Has client been seen by GP in previous 2 week (if not contact GP to liaise)

High risk - Notify within 1day (24hr) ☐	**Low risk** – Consult within 5 days (24hr) ☐
• Height	
• Weight	
• W4H	
• Weight Loss / Timescale	
• Deterioration of physical in crisis	
• Significant decrease in dietary intake	

Triage Outcome/ Summary ie appointment given (date/time) and with whom:

	Date/Time GP informed

	Date/Time GP informed
Non-engagement ☐ *Please ensure attempts of engagement are recorded in RIO progress notes*	

*** ONLY GREEN PAGE TO BE COMPLETED BY SPA ***

Barnsley CAMHS ED Triage — May 2016

BARNSLEY CAMHS
EATING DISORDERS SCREENING ASSESSMENT

Name:	RiO:	DOB:	Todays Date:

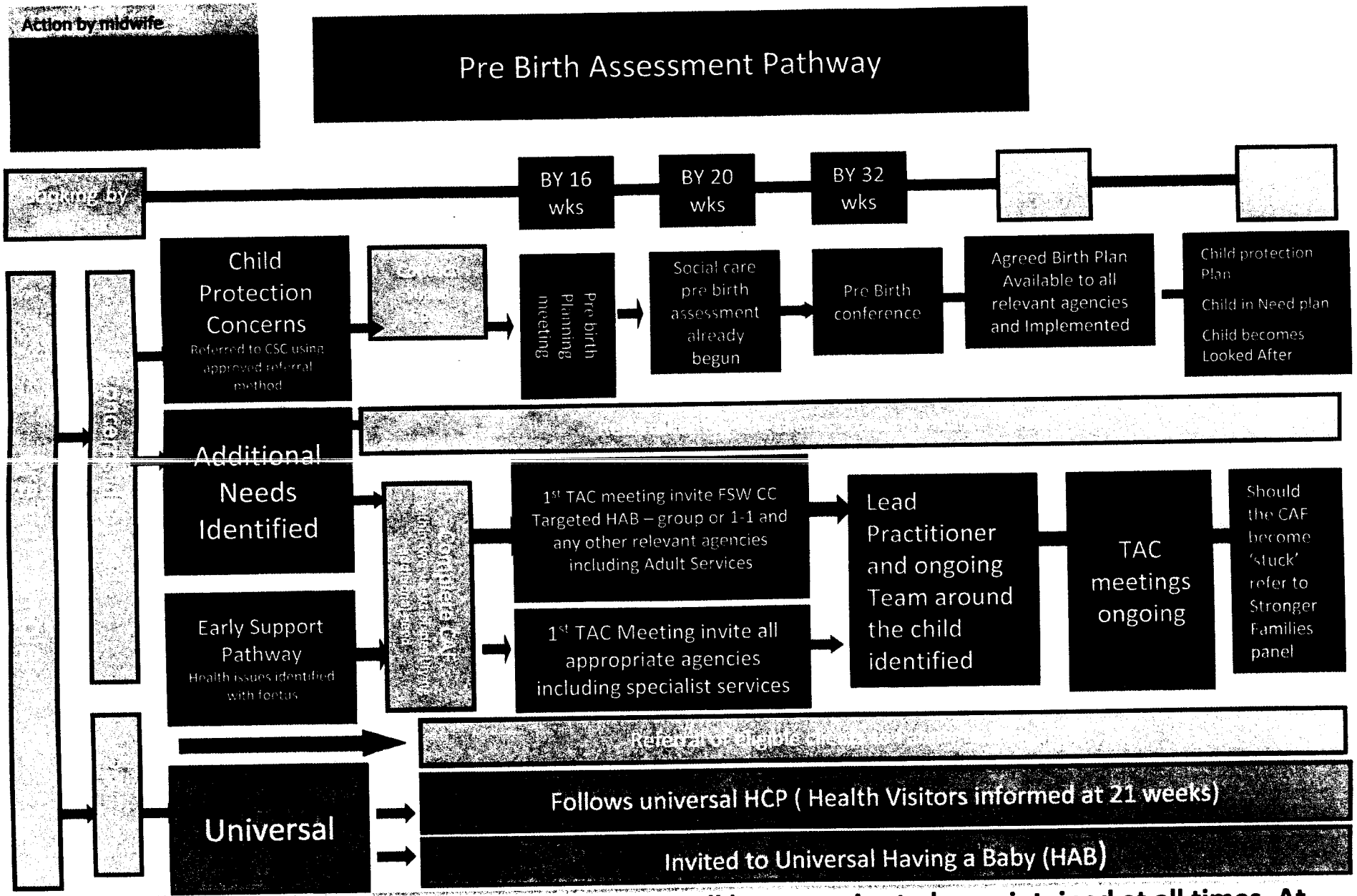
Current weight?			
Current W4H?			
Ideal weight			
What would be different if reached this (ideal weight)?			
Highest ever weight?			
Lowest ever weight?			
Typical day, food wise, starting from when you wake up to when you go to bed:			
Foods will eat? If struggling to answer, take through food groups, e.g. meat, fish, potatoes (all types e.g. chips, baked, mash etc), eggs (all kinds e.g. omelette, scrambled boiled etc), dairy (cream, ice cream, cheese, yoghurt), fruit, veg, chocolate, cakes, crisps			
Foods avoided?			
Meal times/ Meal routines			
Fluids?			
Self-induced vomiting?			
Excessive exercise?	Yes [ ] No [ ] If yes please give details		
Laxative/diuretic/diet pills?	Yes [ ] No [ ] If yes please give details		
Been on any kind of diet?	Yes [ ] No [ ] If yes please give details		
Physical Screen:			
Chest pain?	Yes [ ] No [ ] If yes please give details		ECG Indicated Yes [ ] No [ ]
Shortness of breath?	Yes [ ] No [ ] If yes please give details		
Dizziness?	Yes [ ] No [ ] If yes please give details		

Barnsley CAMHS ED Assessment — May 2016

APPENDIX 3: Barnsley Eating Disorder Triage Pro-forma (Page 3 and 4)

Faints?	Yes [ ] No [ ] If yes please give details	
Abdominal pain?	Yes [ ] No [ ] If yes please give details	
Constipation?	Yes [ ] No [ ] If yes please give details	
Cold extremities?	Yes [ ] No [ ] If yes please give details	
Headaches?	Yes [ ] No [ ] If yes please give details	
Dry skin/hair/hair falling out?	Yes [ ] No [ ] If yes please give details	
Periods – absent, reduced frequency, heavier, lighter?		
Blood results (Circle as necessary)	FBC U&E Glucose (random) Bicarbonate LFT/ GGT TFT Calcium Phosphate Magnesium Creatinine Kinase B12/ Folate Cholesterol	
Other Blood results (please specify):		
Blood pressure/pulse:	Sitting:	Standing:
Weight (no shoes, oat/jumpers off)		
Calculate ideal weight; weight to height ratio; 85% wt for ht and 75% wt for ht; i.e. critical weight.		
Psychiatric Screen:		
Self-image		
Distorted body image?	Yes [ ] No [ ] If yes please give details	
Compulsive thoughts?	Yes [ ] No [ ] If yes please give details	
Mood		
Sleep		
Appetite		
Family stability		
Concentration		
Ambition / Aspiration		
Suicidal thoughts/plans/actions?	Yes [ ] No [ ] If yes please give details	
Energy		
Motivation		
Interest (loss of)	Yes [ ] No [ ] If yes please give details	

Family history of any eating disorder?	Yes [ ] No [ ] If yes please give details	



Communication/sharing of information between all key agencies to be maintained at all times. At any point a child could move between the four tracks if circumstances change.

.10 Children At Risk Where A Parent Has A Mental Health Problem

print

Contents

Introduction

1. The mental health of a parent or carer does not necessarily have an adverse impact on a child but it is essential to assess the implications for the child. If any agency has concerns that a child is at risk of harm because of the impact of the parent/carer's mental health they should check to see if the child is subject to a **Child Protection Plan – see Recording that a Child is the subject of a Child Protection Plan Procedure.**

2. Children are at greatest risk when:

    - the child features within parental delusions
    - the child becomes the focus of the parent's aggression.

    In these circumstances the child should be considered at immediate risk of harm and a referral made to Children's Social Care Services in accordance with the **Referrals Procedure.**

3. Where it is believed that a child of a parent with mental health problems may be at risk of significant harm, a **Strategy Discussion/Meeting** should be held and consideration should be given to undertaking a **Section 47 Enquiry**

4. In circumstances whereby a parent/carer has mental health problems it is likely there are a number of professionals involved from different services. It is important that these professionals work together within enquiries and assessments to identify any links between the parent's mental health, their parenting, and the impact on the child. Any assessment should include an understanding of the needs of the family and children and an identification of the services required to meet these needs.

Guidelines for Joint Working

6. It is essential that staff working in adult mental health and child care work together within the application of child protection procedures to ensure the safety of the child and management of the adult's mental health.

7. Joint work will include mental health workers providing all information with regard to:

    - treatment plans
    - likely duration of any mental health problem
    - effects of any mental health problem and medication on the carer's general functioning and parenting ability.

8. Child protection workers must assess the individual needs of each child and within this incorporate information provided by mental health workers.

9. Mental health professionals must attend and provide information to any meeting concerning the implications of the parent/carer's mental health difficulty on the child. These will include:

    - **Strategy Meetings**
    - Initial and Review **Child Protection Conferences**
    - **Core Groups.**

10. Child care professionals must attend Care Programme Approach (CPA) and other meetings related to the management of the parent's mental health.

11. All plans for a child including **Child Protection Plans** will identify the roles and responsibilities of mental health and other professionals. The plan will also identify the process of communication and liaison between professionals. All professionals should work in accordance with their own agency procedures/ guidelines and seek advice and guidance from line management when necessary.

Contingency Planning

12. Child care and mental health professionals should always consider the future management of a change in circumstances for a parent/carer and the child and how concerns will be identified and communicated. This may include:

Mentally ill parents and children's welfare

By Richard Green (February 2002)

Key points

The extent to which parental mental illness effects the standard of parenting and children's safety or welfare hinges on a number of factors. A small number of children die or are seriously harmed by a mentally ill parent. Many more children suffer less dramatic effects as their own development or mental health becomes compromised. There is a *'hidden problem'* around children who care for a mentally ill parent ('young carers') who may miss out on many opportunities. The *'scale of the problem'* is not known but it has been estimated that psychiatric morbidity amongst parents is about 16%. There are many barriers - legal, structural, professional, financial - to the creation of services which tackle both parental mental illness and children's welfare but some interesting initiatives have been set up.

The impact upon children

Parental mental illness takes many different forms. Its impact upon children varies according to a host of factors. One is the severity and duration of the illness. For instance, a temporary and minor illness handled by primary care services is likely to be much less disruptive to family life than a severe and chronic psychotic illness requiring lengthy hospitalisation. Other variables include the child's age and resilience, the presence or absence of a *'well'* parent/ carer and the extent to which the illness pervades all aspects of family life (Rutter, 1989). It is tempting, but inadvisable, to give undue weight to the psychiatric diagnosis. As Reder et al (1993) point out, the telling factor is not the diagnosis as such but the parental *behaviour*.

So, how does parental mental illness affect children? The research can be distilled into three sub-headings the impact upon parenting, direct effects on children and children who care for a mentally ill parent.

Effects on parenting

There is a body of literature and research (Murray, 1996; Ethier et al, 1995; Dore, 1993; Sheppard, 1993) which points to those suffering mental illness having impaired social performance and disproportionately conflictual relationships. Parenting may be adversely affected. Ethier et al (1995), for instance, found that clinically depressed mothers were more likely to speak less often to children, enforce obedience unilaterally and react in more hostile and irritable fashion. Murray (1996) produced similar findings of social disadvantage, relationship problems with children and the latter having increased levels of behaviour difficulties.

A small study of parents who use mental health services (Hugman and Phillips, 1993) showed that all thought their relationships with their children had suffered at some point. It is generally held that parental mental illness is a risk factor in respect of child abuse (Sheppard 1993). Forthcoming research into serious injuries sustained by children under 24 months suggests many parents had poor mental health (Dale, Green and Fellows, forthcoming) though a formal diagnosis of mental illness was relatively rare. Research (cited in Dore, 1993) which has inquired into causal relationships between parental mental illness and abuse has produced mixed findings

Direct effects on children

There is a second body of literature/ research which has covered much of the same territory but from the perspective of child welfare. A pioneering paper by Kempe et al (1962) posited that psychiatric factors were probably *'of prime importance'* (Kempe et al, 1962, p.17) in the aetiology of child abuse. Subsequent research has suggested that the causes of child abuse are generally more complex and multi-factorial. Nonetheless, Bell et al (1995) found parental mental illness recorded as a factor in 13% of cases referred for child protection concerns. A number of children suffer permanent injury or die at the hands of mentally ill parents (Falkov, 1995), typically during an acute

phase of an illness. Also a small number are seriously harmed or die as a

consequence of a carer, generally the mother, suffering from Munchausen's Syndrome by Proxy (see e.g. Bools et al, 1994).

Nonetheless, the greatest risk to the majority of children is not one of life and limb. It is rather the threat to their own attachments, development and mental health (Rutter, 1989). Rutter and Quinton (1984) concluded that one-third of the children of new psychiatric cases exhibited a persistent disorder, this being twice the rate found in the control group. A recent study (Singer et al, 2000) found high rates of psychiatric disturbance within a small sample of children of psychiatric in-patients, many of these children being unknown to services. Reid and Morrison (1983) suggested that young children are particularly vulnerable, as are the children of psychotic parents. The issue of whether psychosis poses more risk than, say, depression is a typically complex one within this field and, as with many issues, best treated with caution. For instance, Cassell and Coleman (1995) posit that children are at increased risk if incorporated into parental psychotic ideation conversely, other research (see Dore, 1993) showed no differences in outcomes between children of psychotic and depressed parents.

Children who care for a mentally ill parent

Finally, there is a third germane body of literature/research which focuses on children who care for a mentally ill parent. These are commonly referred to as young carers though this is mostly employed as a generic term encompassing children who care for parents for a number of different reasons, including parental physical disability or physical illness. Estimates of the numbers of young carers nationwide vary between 10,000 and 40,000, of which about one-third care for a mentally ill parent (Dearden and Becker, 995). Care is more likely to be provided by girls than boys and may well have a physical and emotional component. It is also likely to be provided to younger siblings as well as ill parents. A number of personal accounts (Marlowe, 1996) and reports (SSI, 1996) point to the difficulties experienced by a proportion of young carers. The problem is not the caring per se - indeed, many young carers report a wish to undertake this role. It is the missing out on educational, social and leisure activities that is sometimes concomitant with this role. Young Carers are something of a *'hidden problem'*, being either unknown to services or being left to cope.

Our own study (NSPCC, 1997) contained some poignant accounts of children acting as carers and of the costs thus incurred. It also showed that many of these children had significant experiences of loss, self-blame and stigma.

The scale of the problem

Accurate data as to the percentage of mentally ill parents who have dependent children is not systematically recorded (Falkov, 1997). Indeed, at the point of first contact with mental health professionals many recipients of mental health services are not identified as parents (Blanch et al, 1994). Thus, information as to the scale of the problem is largely based on estimates. Within this context, Gopfert estimates that one half of all mentally ill adults are parents living with dependent children (Gopfert et al, 1996). Meltzer et al (1995) estimate the psychiatric morbidity among parents nationally to be 16%.

There are a number of studies which examine the prevalence of mental illness amongst adults (not necessarily parents) which suggest that prevalence is governed to some extent by gender, ethnicity and class. It is known, for example, that twice as many women as men suffer from depression (Sheppard, 1993) and that depression is a particularly common disorder amongst women of child-bearing age (Downey and Coyne, 1990). A seminal work established that working class women were four times more likely to suffer from a psychiatric disorder than their middle class counterparts (Brown and Harris, 1978). There are differential rates of prevalence within different cultures. This may reflect a link between social stress (racism unemployment, poverty etc) and mental illness (see e.g. Littlewood and Lipsedge, 1989). However, the picture is complex as there is not a clear one-to-one relationship between social disadvantage and mental illness. One difficulty is that the term *'mental illness'* is itself culturally-bound; mental health may manifest itself differently in different cultures. Community based studies suggest that prevalence rates are about 1% for schizophrenia, 5% for depression, 10% for personality disorders and 10-30% for anxiety disorders (quoted in Cleaver et al, 1999).

Research into the field of mental illness is mired in definitional / methodological difficulties. For instance, a number of studies might all examine *'mental illness'* but be looking at very different phenomena. Some studies are drawn from samples of psychiatric in-patients whilst others are drawn from the community at large, depending mostly on respondents' self-report. It does not necessarily follow that the findings drawn from a psychiatric sample examining psychosis can be compared or integrated with those examining those suffering depression in the community. Equally, some studies include alcohol and substance abuse whilst others exclude these.

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Other organisations to contact

- **Association for Child and Adolescent Mental Health**

www.acamh.org.uk

- **Mental Health Foundation**
  www.mentalhealth.org.uk
- **MIND**
  www.mind.org.uk
- **YoungMinds**
  www.youngminds.org.uk

This research briefing is based on a review of research and literature. It reports the findings and views of a range of authors. These views are not necessarily the views of the NSPCC.

Although the websites listed here are checked regularly the constantly changing nature of the internet means that some sites may alter after we have viewed them. The NSPCC is not responsible for, nor does it necessarily endorse, the content of these external websites.

Help for children & young people
0800 1111

Help for adults
0808 800 5000

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

FR/LP/02

Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP)

Faculty of Liaison Psychiatry
Royal College of Psychiatrists

FACULTY REPORT

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Faculty Report FR/LP/02

May 2015

Contents

Background

Over the past few years there has been an increasing focus upon outcome and performance measurement in liaison psychiatry services. Various options and approaches have been considered, but without identification of an agreed way forward. This has become particularly important due to the fact that, although there is mounting evidence for the economic benefit of liaison psychiatry services, there is a relative lack of information and evidence relating to clinical and other outcomes (Fossey & Parsonage, 2014).

Over the same period there has been an increasing emphasis, across the NHS, upon the need to establish the collection of outcomes data as a matter of routine. All of this has been moving forward in the context of the NHS quality agenda (Dept. of Health, 2011):

- Effective services
- Safety
- Positive patient experience

Three main types of outcome measures have been proposed, and are now seen as an absolute requirement within NHS services:

1. CROMS - Clinician-Rated Outcome Measures
2. PROMS - Patient-Rated Outcome Measures
3. PREMS - Patient-Rated Experience Measures

Attempts have been made, particularly by the RCPsych Faculty of Liaison Psychiatry, to reach a conclusion as to what measures should be recommended for use across all liaison psychiatry services, in order to promote a consistent approach. This has involved work by a range of individuals at strategy days and in workshops at two annual residential conferences.

Elements of this were fed into the work then carried out by colleagues at the Centre for Mental Health, which led to the production of a report entitled Outcomes and Performance in Liaison Psychiatry: developing a measurement framework (Fossey & Parsonage, 2014). This important report provided a clear and structured account of the issues faced in attempting to measure outcomes consistently in liaison psychiatry, and suggested some possible ways forward.

The aim of this paper is to build upon the clarity of approach provided in the aforementioned report, by providing a framework for routine outcome measurement across liaison psychiatry services, with the inclusion of specified measures for all services to use.

Key Points to consider, from the Centre for Mental Health Report:

- Outcome and performance measurement in liaison psychiatry services is at present very variable in content and quality.
- Liaison psychiatry services operate in a number of different settings and clinical environments, carrying out a wide range of different activities in support of patients suffering from many different types of clinical problems.
- Most measurement frameworks for assessing quality and performance of services build upon the longstanding "logic model" developed in the 1960's, with the focus upon the following three aspects:
    1. **Structure;** the key resources or inputs available in the settings concerned.
    2. **Process;** what is actually done in the delivery of healthcare in terms of specific activities, with measurement based on quantifiable outputs such as the numbers of patients seen/ treated.
    3. **Outcome;** referring to any consequence of healthcare in terms of changes or benefits which result from the activities and outputs of the service in question.

(Donabedian, 1966)

As also identified in the Centre for Mental Health Report:

a. The best strategy for assessing quality and performance is to include a mix of indicators drawn from the three dimensions of structure, process and outcome: the so-called "balanced scorecard" approach.
b. The complexity and heterogeneity of the service provision in liaison psychiatry necessarily rules out any (single) very simple, all-purpose approach to the measurement of the outcomes of performance in this context.

FROM-LP

Building upon all of this, there is a clear need for an explicit framework defining, across the various settings and in relation to the various actions carried out by liaison psychiatry teams, what should be measured and how. No single instrument can be universally applied across the whole of liaison psychiatry, necessitating the need for different groups of outcome measures (ie scorecards) in different contexts, but it will be crucial to ensure that the approach is as simple, as easy and, therefore, as consistently deliverable as possible.

In line with this aim, and considering all of the above, it is proposed that the **Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP)** is adopted across all liaison psychiatry services in the NHS. This would enable consistency of data collection and the effective reporting of outcomes in individual liaison psychiatry services, in a way which would allow our various 'customers' (patients, carers, referrers and commissioners) to understand and have confidence in the beneficial effects of liaison psychiatry services. This initiative is being introduced at a critical time, when liaison psychiatry services need to move rapidly to a position of being able to say something useful about what they do, from an outcomes perspective.

Improvements in the approach may come later, perhaps as a result of experience of using the Framework, but we need to move forward with this as a matter of some urgency. To continue to discuss and attempt to find a "perfect" approach before introducing anything would be unwise.

In consideration of the "logic model", outlined above, the proposal is for Structure (inputs) to be an issue for local services and for the Psychiatric Liaison Accreditation Network (PLAN).

FROM-LP will focus upon brief, simple, easy and deliverable data collection regarding Process and, in particular, Outcomes (spanning clinician-rated clinical outcomes, patient-rated clinical outcomes, patient-rated satisfaction, and referrer-rated satisfaction).

In order to keep this as simple and deliverable as possible, FROM-LP defines only **two clinical case types**, according to whether they involve a **single clinical contact** or a **series of clinical contacts** by the liaison psychiatry team. This is of course partly determined by the setting, but for routine and simple outcome measurement the setting need not determine the measurement approach.

(It is acknowledged that services may have some additional local data collection requirements, beyond those stipulated in this Framework.)

FROM-LP outcome measurement requirements:

1 CASE TYPE 1: SINGLE CONTACT

(ED, SH assessments, in-reach assessment, etc)

Process

- Response time (routine/urgent/emergency - avoidance of breaches)
- Identify the aim / rate achievement of the aim (see "IRAC" tool below)

Outcomes (clinician-rated)

- CGI-I

Outcomes (patient-rated)

- Generic - Nil
- Condition specific - Nil

Patient satisfaction

- Patient satisfaction scale
- Friends and family test

Referrer satisfaction

- Referrer satisfaction scale (case by case or as a regular survey - see below)

2 CASE TYPE 2: SERIES OF CONTACTS

(Clinics, brief or longer-term interventions, in-reach interventions, etc)

Process

- Response/waiting time (waiting list - avoidance of breaches)
- Identify the aim / rate achievement of the aim (see "IRAC" tool below)

Outcomes (clinician-rated)

- CGI-I

Outcomes (patient-rated)

- Generic - CORE-10
- Condition specific (see Appendix 2)

Patient satisfaction

- Patient satisfaction scale
- Friends and family test

Referrer satisfaction

- Referrer satisfaction scale (case by case or as a regular survey - see below)

(The relevant tools and scales are shown in Appendix 1.)

FROM-LP: summary table

	CASE TYPE	
MEASUREMENT		
	SINGLE CONTACT	**SERIES OF CONTACTS**
PROCESS:	**1) Response time** **2) IRAC**	**1) Response/waiting time** **2) IRAC**
OUTCOMES (clinician-rated)	**3) CGI-I**	**3) CGI-I** (at beginning and end of series of contacts)
OUTCOMES (patient-rated)		**4) CORE-10** (at beginning and end of series of contacts)
PATIENT SATISFACTION	**4) Patient satisfaction scale** **5) Friends and family test**	**5) Patient satisfaction scale** **6) Friends and family test**
REFERRER SATISFACTION	**6) Referrer satisfaction scale** (as a regular survey if frequent referrers)	**7) Referrer satisfaction scale** (as a regular survey if frequent referrers)

NOTE:

These measures are to be collected routinely (ie in all relevant cases).

They are at the level of the individual contact and the intention is that they are simple and easy to administer, to achieve consistent collection.

For Case Type 1: Experience suggests that it is too much to ask of our very frequent referrers (eg ED, or medical wards which routinely take self-harm admissions, etc) to complete the Referrer Satisfaction Scale for every case. In such settings, a regular survey of the relevant staff (referrers) is recommended instead, eg quarterly (every 3 months) But in relation to services which refer less frequently, the Referrer Satisfaction Scale should be used on every occasion.

For Case Type 2: In addition to using CORE-10 as a generic patient-rated outcome measure, consideration may be given to the use of condition specific measures (see Appendix 2).

For cases which do not involve direct patient contact (ie are at a systemic / clinical team level) use:

1. IRAC
2. Referrer satisfaction scale

Other measurement of:

- Patient demographics, referral source, referral profile, discharge destination, etc
- Structure (resources and inputs)
- Process in a broader sense (eg number of patients seen/treated)
- Education and training of general hospital staff/teams
- Impact on local health service use
- etc

will necessarily be via local monitoring systems.

APPENDIX 1

Relevant scales

1 IRAC: Identify and Rate the Aim of the Contact

Specify the main aim of the contact (tick one box):		Was this achieved?
Assessment and diagnosis/formulation	[ ]	
Providing guidance / advice	[ ]	Fully achieved 2
Signposting / referring on	[ ]	
Assessment and management of risk	[ ]	
Assessment of mental capacity	[ ]	Partially achieved 1
Assessment re: Mental Health Act	[ ]	
Medication management	[ ]	
Management of disturbed behaviour	[ ]	Not achieved 0
Brief psychological interventions	[ ]	
Treatment (other)	[ ]	

(Trigwell P, 2014a)

2 CGI-I: Clinical Global Impression - Improvement scale

Compared to the patient's condition at the start of assessment, his/her condition is:						
Very much improved	Much improved	Minimally improved	No change	Minimally worse	Much worse	Very much worse
1	2	3	4	5	6	7

(Guy W, 1976)

(The wording of the CGI-I has been altered slightly, to enable it to be applicable to single contact episodes and to the context of liaison psychiatry work, by replacing "at admission" with "at the start of assessment".)

3 Patient satisfaction scale

How would you rate the service you have received from (name of service)?				
Excellent	Good	Average	Poor	Very poor
4	3	2	1	0

What has been good about the service you have received?
What could be improved?

(Persaud A et al, 2008)

4 Friends and family test

How likely are you to recommend this service to friends and family if they need care or treatment?					
Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know
1	2	3	4	5	6

(Department of Health, 2012)

5 Referrer satisfaction scale

For an individual case:

In relation to this patient's care, how would you rate the service received from (name of service)?				
Excellent	Good	Average	Poor	Very poor
4	3	2	1	0

For a staff/referrer survey:

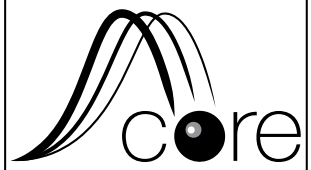
In general, how would you rate the service received from (name of service)?				
Excellent	Good	Average	Poor	Very poor
4	3	2	1	0

Also, for either:

What has been good about the service you have received?
What could be improved?

(Trigwell P, 2014b / after Persaud A et al, 2008)

6 CORE-10 (example sheet)



CORE - 10

Site ID

letters only | numbers only

Client ID

Therapist ID | numbers only (1) | numbers only (2)

Sub codes

Date form given D D / M M / Y Y Y Y

Age

Male ☐ **Female** ☐

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last Therapy Session
X Follow up 1
Y Follow up 2

Stage

Episode

IMPORTANT – PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	*Not at all*	*Only Occasionally*	*Sometimes*	*Often*	*Most or all the time*
1 I have felt tense, anxious or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2 I have felt I have someone to turn to for support when needed	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3 I have felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4 Talking to people has felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5 I have felt panic or terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6 I made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7 I have had difficulty getting to sleep or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8 I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9 I have felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10 Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Total (Clinical Score*) ☐

* **Procedure**: Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.

Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

331/29

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

(Barkham et al, 2013)

Register free to use CORE-10 and to download forms at:
www.coreims.co.uk/Downloads_Forms.aspx

APPENDIX 2

Condition Specific Measures

The Liaison Psychiatry Faculty of the RCPsych is currently carrying out work to clarify appropriate condition specific measures which can and/or should be used in clinical work within liaison psychiatry services. This initiative is expected to lead to a conclusion during 2015.

Possibilities identified to date (in accordance with relevant NICE Guidance, where available):

1	Dementia:	ACE-R
2	Depressive disorders:	PHQ-9
3	Postnatal depression:	Edinburgh Postnatal Depression Scale
4	Anxiety disorders:	GAD-7
5	Psychosis:	HoNOS
6	Alcohol:	AUDIT-C
7	Eating disorders:	BMI
8	MUS:	EQ-5D-5L

NO specific measures recommended for:

1. Delirium
2. Self-harm
3. Personality disorders
4. Violence

Other related work

Progress in this area will also be informed in time as a result of the recently commissioned National Institute for Health Research HS&DR project **LP-MAESTRO (Measurement and evaluation of service types, referral patterns, and outcomes)**, being led by Professor Allan House, Dr Peter Trigwell and colleagues. Both PLAN and the Liaison Psychiatry Faculty of the RCPsych are linked with and involved in this important project.

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Contents

Admissions 2014/15

CCG	Adolescent	Child
NHS Barnsley CCG - 02P	9	1

Service Category 2014/15

CCG	Adolescent	Child
NHS Barnsley CCG - 02P	11	1

Occupied bed days 2014/15

CCG	Adolescent	Child
NHS Barnsley CCG - 02P	370	13

ED	LD	Low Secure	Medium Secure	PICU

ED	LD	Low Secure	Medium Secure	PICU

ED	LD	Low Secure	Medium Secure	PICU

Grand Total
10

Grand Total
12

Grand Total
383

Admissions 2015/16

CCG	AC	CLD
NHS BARNSLEY CCG	11	

Service Category 2015/16

CCG	AC	CLD
NHS BARNSLEY CCG	13	

Occupied bed days 2015/16

CCG	AC	CLD
NHS BARNSLEY CCG	781	

ED	Low	Med	PICU	UKNC
1				1

ED	Low	Med	PICU	UKNC
1				1

ED	Low	Med	PICU	UKNC
18				3

Grand Total
13

Grand Total
15

Grand Total
802

CAMHS / All Placement Reasons

CCG of Patient	Average Distance from Home (Miles)	Greatest Distance from Home (Miles)
NHS Barnsley CCG	17.67	36.16

Least Distance from Home (Miles)	% Patients Placed In-Region
11.21	81.82%

Spend per CCG and per provider	Sum of total costs
NHS BARNSLEY CCG	£622,184
Sheffield Children's NHS Foundation Trust	£622,184

Barnsley Clinical Commissioning Group

Putting Barnsley People First

Future in Mind – Local Transformation Plan Implementation Group

Terms of Reference

NHS Barnsley Clinical Commissioning Group
Future in Mind – Local Transformation Plan Implementation Group

1. Introduction

1.1 Barnsley CCG and partners have established a Future in Mind Implementation Group to ensure delivery of the assured Barnsley Local Transformation Plan. Oversight of the performance of the higher level support CAMHS services (previously referred to as Tier 3 services), within the Barnsley system of care and support for children, young people and their families will be undertaken via the normal contractual mechanisms and the appropriate Clinical Quality Board.

2. Purpose

2.1 The primary purpose of the 'Future in Mind' Group is to work collaboratively with all parties to ensure effective implementation of and continuous monitoring of the Barnsley Local Transformation Plan to enable delivery of sustained improvement in the emotional Health and Wellbeing of the Children and Young People in Barnsley. The 'Future in Mind' Group will also further develop plans for continued delivery of these improved outcomes over the next five years.

3. Responsibilities

3.1 The responsibilities of the Group will be as follows:-

- To provide a forum for open, honest and transparent dialogue to ensure implementation of the actions outlined within the Local Transformation Plan.

3.2 To agree who/which organisation will lead the delivery of each of the Local Priority Streams outlined in the LTP and to work collaboratively to ensure organisational barriers do not impede effective delivery of the desired outcomes of the Plan;

- To develop metrics/KPIs against which effective delivery of the LTPs objectives can be measured;

- To provide quarterly assurance to NHS England of the appropriate investment of FiM monies and the impact this investment has on the emotional health and wellbeing of children and young people in Barnsley.

4. Stakeholders

(a) Barnsley CCG Chief Nurse (Chair)
(b) Barnsley CCG Head of Commissioning Mental Health, Children's and Specialised Services
(c) Barnsley CCG Clinical Lead

(e) BMBC Family Centres & Early Years
(g) BMBC Education Psychology
(h) BMBC Youth Offending Team
(i) Public Health
(j) Secondary Schools Representative
(k) Primary Schools Representative
(l) SWYPFT District Director – Forensics & CAMHS and/or SWYPFT Deputy Director CAMHS
(n) SWYPFT Clinical Lead/Senior Clinician

(q) School Nursing Service

The Group will be serviced by the administrative support to the Chief Nurse.

5. Meetings

5.1 There will be 2 Stakeholder Engagement Events held each year (March and September).

5.2 Local Priority workstream leads will meet on a monthly basis and these meetings will be facilitated by the CCG

6. Governance

6.1 The Group will be a Sub-Group of the Children & Young People Executive Commissioning Group.

7. Reporting Arrangements

7.1 Agendas and papers will be distributed to Stakeholders / workstream leads by email, one week prior to the relevant meeting.

7.2 The minutes/action log will be distributed to stakeholders / workstream leads, by the administrative support to the Chief Nurse, no later than two weeks after the relevant meeting.

7.3 A highlight report will be agreed and submitted to the Children's Executive Commissioning Group following each Stakeholder Engagement event. A verbal update as to progress of the implementation of the Transformation Plan will be given at every ECG.

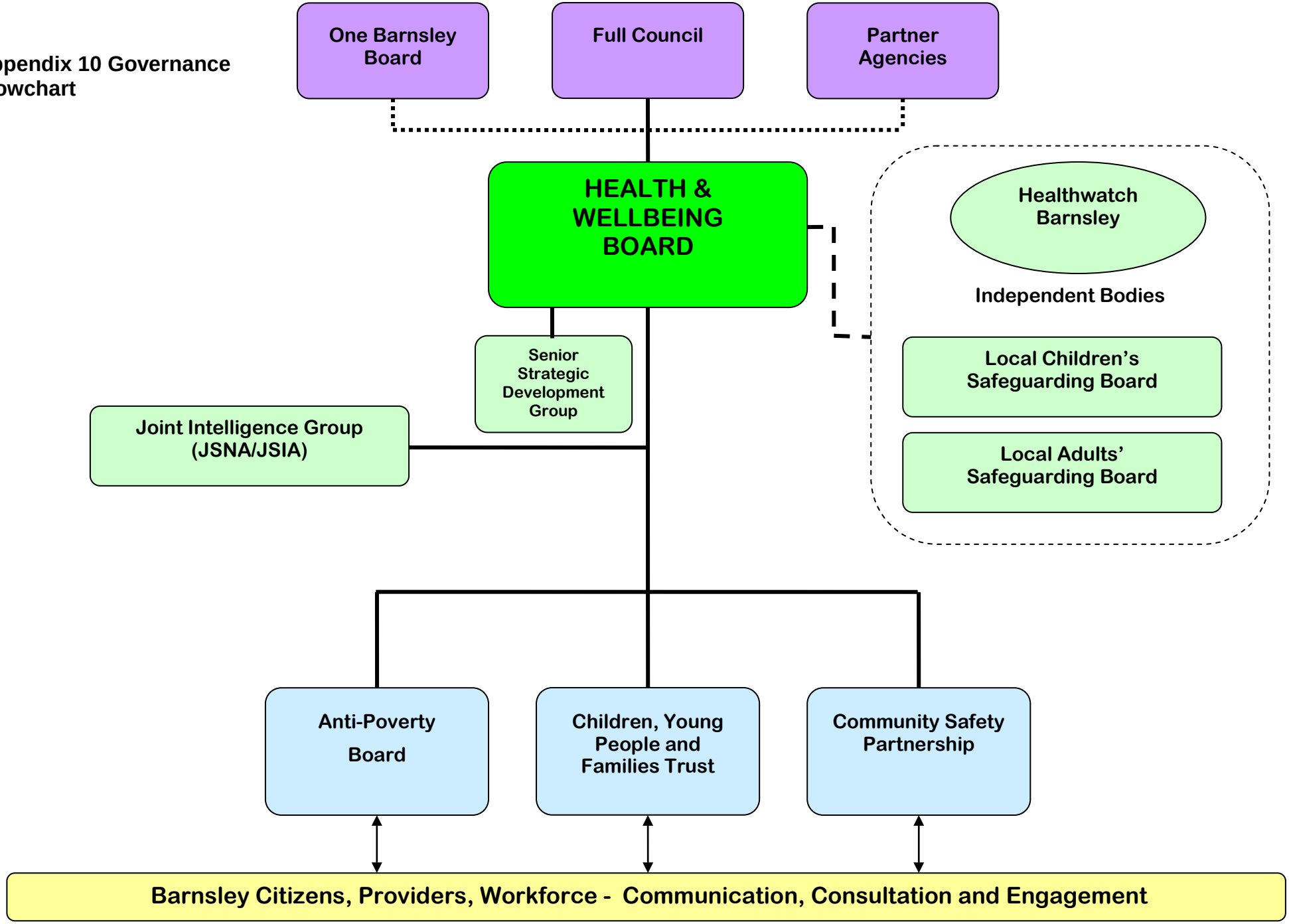
7.4 Trackers will be submitted by the Chief Nurse's administrative support to NHS England on a quarterly or as required basis.

9. Duration

9.1 The Stakeholder Events and monthly workstream leads meetings will continue until such time as the members agree that a system wide sustainable low level emotional health & wellbeing support for Children & Young People exists in Barnsley and is delivering desired outcomes.

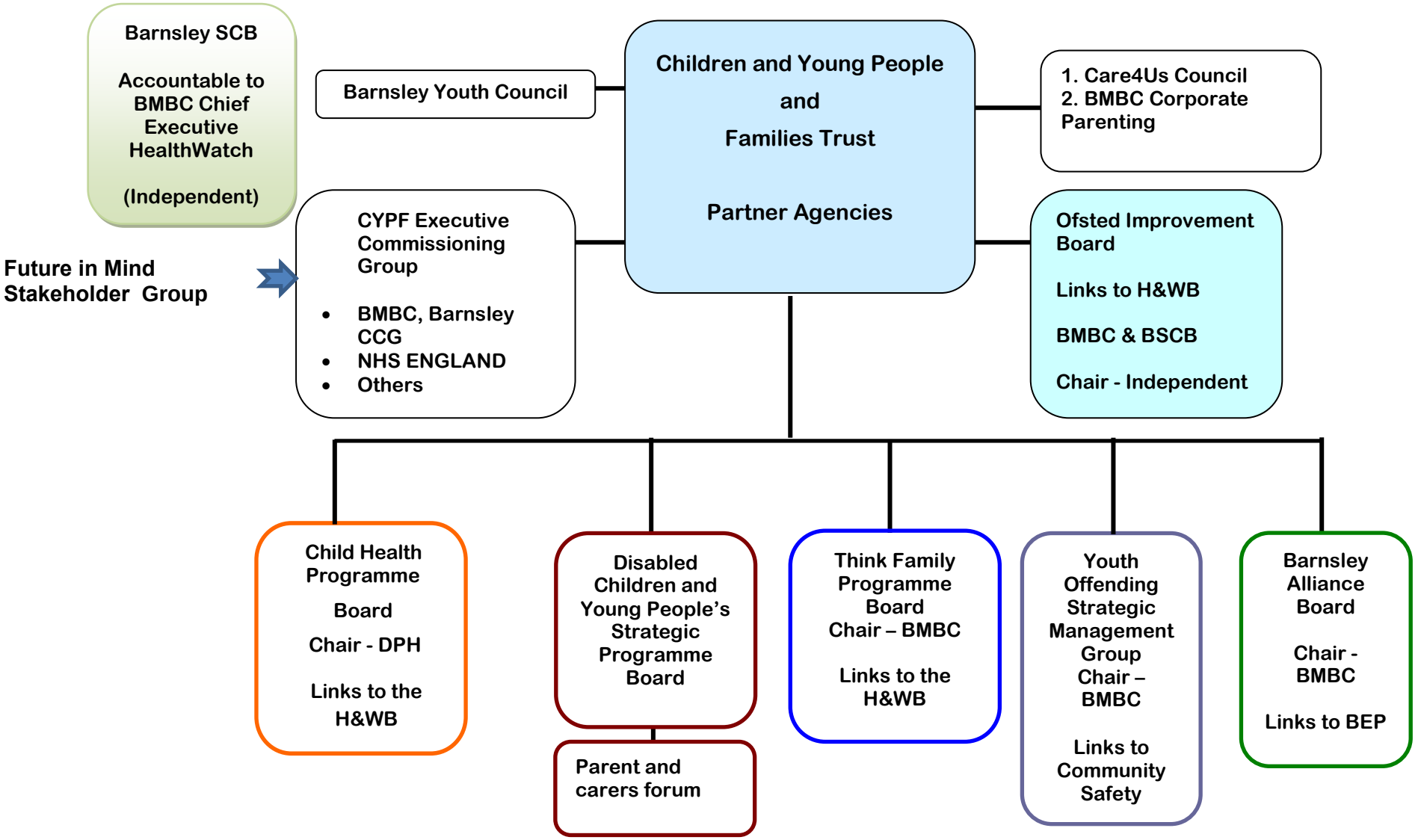
Last Reviewed: July 2016
Next Review Due: July 2017

Appendix 10 Governance Flowchart



Proposed networks for the Barnsley Children, Young People and Families Trust

Partnership groups connected to the CYPFT



Department of Health

From David Mowat MP
Parliamentary Under Secretary of State for Community Health and Care

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

FAO Health and Wellbeing Board Chairs

14 DEC 2016

Dear Chair,

I am writing to you in your capacity as local Health and Wellbeing Board Chair to highlight the Government response to the independent Review of Choice in End of Life Care.

This document set out the Government's commitment to everyone approaching the end of life, and I ask you to consider this commitment at this important time for your local area as Sustainability and Transformation Plans (STPs) are further developed, and Clinical Commissioning Groups (CCGs) finalise Operational Plans for the coming years.

Our ambition is for everyone approaching the end of life to receive high quality care that reflects their individual needs, choices and preferences, regardless of where they live.

On 5th July, we set out plans to improve end of life care in England. Our proposals were based on a commitment to high quality, personalised end of life care that we are making to all people at, or approaching the end of life. The commitment states that everyone should be able to expect:

- honest discussions between care professionals and dying people;
- dying people making informed choices about their care;
- personalised care plans for all;
- the discussion of personalised care plans with care professionals;
- the involvement of family and carers in dying people's care;
- a key contact so dying people know who to contact at any time of day.

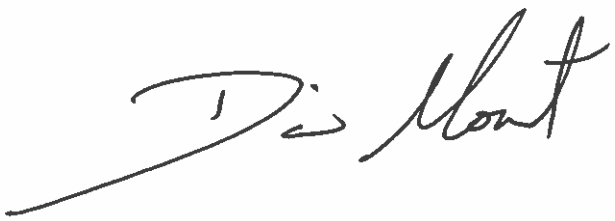
I am aware of the many priorities you have at a local level, but I am asking you to consider how you can encourage your colleagues locally to consider the importance of end of life care as local strategies and priorities are finalised.

A key element of the commitment is bringing together the NHS, social care and the voluntary sector to deliver seamless, person-centred care. Good end of life care is not the responsibility of one person or organisation: it happens because professionals and organisations work together.

There is a real opportunity over the coming years to ensure innovative ideas are put to work to deliver better outcomes for dying people. The Government fully supports the Ambitions for Palliative and End of Life Care Framework, which encourages local health leaders to develop strategies for palliative and end of life care which involve all providers and relevant stakeholders.

NHS England and the National Council for Palliative Care have launched a *Palliative and End of Life Care Knowledge Hub* bringing together resources and tools to support commissioners and providers to drive delivery of the Ambitions Framework. More information is available at: http://endoflifecareambitions.org.uk/.

In summary, I am asking you and your colleagues to consider how you can encourage action to improve end of life care, specifically through Operational Plans and STPs, to ensure everyone receives the high quality, personalised care at the end of life they deserve.



DAVID MOWAT

REPORT TO THE HEALTH AND WELLBEING BOARD

Date: 31st January 2017

PALLIATIVE AND END OF LIFE CARE: POSITION PAPER

Report Sponsor:	Janet Owen (End of Life Care Clinical Lead) South and West Yorkshire Partnership NHS Trust and Chair of Barnsley End of Life Care Clinical Steering Group
Report Author:	Richard Lynch (Head of Commissioning, Governance and Partnerships) Barnsley MBC
Received by SSDG:	17th January 2017
Date of Report:	19th January 2017

1.0 Purpose of Report

1.1 To inform the Board of current provision for palliative and end of life care in the Borough, following the recent publication of the Government's response to the recent independent review of choice in end of life care.

2.0 Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Note the priorities of the Barnsley End of Life Care Strategy and the outcomes of a review of the Strategy, together with the extent to which local service provision for palliative or end of life care, in the Borough, is continually informed through developments in policy, including the Government's recent response to the independent review.

3.0 Background and Context

3.1 In 2008 the Department of Health (DH) published the first National End of Life Care Strategy as a 10 year plan. Following this, in 2010, a Barnsley Strategy was written to provide a vision and direction for local services. In 2015 the Barnsley End of Life Care Strategy was reviewed and refreshed by Barnsley CCG to build on the original recommendations and consider future priorities in light of changes in practice and national reports including "More Care Less Pathway"(2013) and "One Chance To Get It Right" (2014).

3.2 Since then, there has been a number of further reports including Ambitions For Palliative And End Of Life Care Framework (2015) National Institute for

Clinical Care Excellence (NICE) Guidelines For Care Of The Dying Adult In The Last Days Of Life (2015) Commissioner Check List For End Of Life Care (2016) and most recently the DH's response To The Independent Review Of End Of Life Care (2016) and NHS England's Specialist Level Palliative Care: Information for Commissioners (2016). All of these reports have been considered by the Borough's end of life care clinical steering group and informed the development of local services.

3.3 In 2015, a review which was undertaken of the local Strategy reinforced a commitment to provide high quality end of life care for people across the borough irrespective of diagnosis, socio- economic background, religious belief, gender or ethnicity. It focused on patient choice and the development of services which are tailored to individual needs and preferences as part of a fully integrated approach which places Barnsley people at the centre.

3.4 The original scope of the local strategy was to focus on individuals aged over 18 but the review recognised that there are parallels between care for adults and children.

4.0 Current Service Provision In Barnsley

4.1 Palliative or end of life care is provided by a wide range of organisations and services. The strategy makes a distinction between end of life care/palliative care delivered by generalist and specialist services. The specialist team plays an important role in providing education, support and leadership to the generalist teams to facilitate high quality end of life care as well as the provision of direct care for those with complex needs.

4.2 Generalist Services

4.3 A number of generalist services across health and social care providers which deliver end of life care as part of their role. This includes GPs, district nurses, community matrons, care home staff, domiciliary carers, allied health care professionals, social workers, ward doctors and nurses.

4.4 Specialist Services

4.5 The specialist palliative care and end of life care service in Barnsley is jointly provided by Barnsley Hospital, Barnsley Hospice, South West Yorkshire Partnership Foundation Trust (SWYPFT) and Barnsley Council (BMBC). There are close working relationships across the providers which are strengthened by a joint end of life care clinical steering group and an operational /educational group which focus on the development of an integrated and seamless approach for those with end of life care needs.

4.6 The range of care and support provided through specialised palliative and end of life care services is outlined below:

4.6.1 Specialist Palliative Care

Specialist palliative care provision in the community is a 7 day service. The Community Macmillan Specialist Palliative Care Team is employed by SWYPFT and is a multidisciplinary service including clinical nurse specialists, allied health care professionals, a social worker (employed by BMBC) and palliative medicine consultant. The team provides specialist palliative care to patients in a community setting, including clinical nurse specialists specifically for community hospitals and care homes. As part of the SWYPFT's Long Term Conditions Unit, this team is working closely with the new neighbourhood teams which support an integrated community approach.

4.6.2 The Macmillan Specialist Palliative Care Team in Barnsley Hospital provides a 7 day service which includes 5 clinical nurse specialists (3 BHNFT funded and 2 Hospice funded) and a Palliative Medicine Consultant .

4.6.3 Barnsley Hospice provides an inpatient unit (including 10 beds available with 7 day a week admission) and day patient services. The Hospice provides a range of services, including counselling, complimentary therapies, lymphoedema management and a bereavement and family team. A social worker is also employed by BMBC and works at Barnsley Hospice.

4.6.4 Palliative medicine consultants are employed by Barnsley Hospice and work with Hospice, community and hospital teams to provide a district wide service. The Hospice also provides a palliative care advice line and there is telephone advice available from an on call palliative medicine consultant rota.

4.6.5 Palliative Home Care Team

4.6.6 The Marie Curie Supportive Care at Home Team is employed by SWYPFT and includes health care assistants and registered nurses. The team provides support for patients in the last days and weeks of life and their families, providing individualised packages of care to enable a person to be cared for in their preferred place and providing carer respite for those with any life limiting illness.

4.6.7 Clinical Support And Education

4.6.8 The End of Life Care Team is employed by SWYPFT but works with all health and social care providers in Barnsley to support the development of high quality, end of life care through education and clinically based

support/coaching for generalist staff . The service has introduced and supports generalist use of tools for improving end of life care across Barnsley.

5.0 Review Of The Barnsley End Of Life Care Strategy (2015)

5.1 In 2015, the Barnsley CCG led a review of the local end of life care strategy. Provision was considered against national and local expectations and key recommendations were identified to further develop the quality of end of life care provided in Barnsley.

5.2 The review recognised the progress already made in the following categories:

- Collaboration and Integration
- Education /Training
- Care Planning.

5.3 The importance of a collaborative and whole borough approach was central to the end of life care strategy and the development of a single integrated pathway has been a significant factor. The refreshed strategy noted some key achievements that have reflected this and which are summarised below:

- The partnership working between health and social care teams
- The development of a district wide end of life care education programme
- The development of a '*My Care Plan'* district wide tool to support individualised care and the development of a personalised care plan for those in the last days or hours of life
- The introduction of the '*Preferred Priorities For Care'* document as a template for advance care planning and the sharing of personal preferences and wishes
- The introduction of a regional '*Do Not Attempt Cardio Pulmonary Resuscitation'* form which is shared by all providers

6.0 Recommendations Of The Strategy (2015 – 2017)

6.1 The strategy review made 5 key recommendations for further service development during this period. The following provides an overview of progress made against these recommendations:

6.2 Recommendation 1: Development of the End of Life Care Clinical Steering Group

- A new end of life care steering group has been established to drive forward the recommendations of the Review. The membership has been broadened and strengthened with representatives from key organisations and supports a collaborative approach to the development of end of life care services. It is hoped that in 2017 integration with social care will be further strengthened by increased engagement with the group. This group reports to the CCG.

6.3 Recommendation 2: Creating consistency and monitoring quality standards

- It has been agreed that the place of death will remain a broad proxy performance measure for developments in end of life care. It is recognised that this does have limitations but is nationally recognised as providing a broad bench mark. Local data has shown a steady trend of increasing numbers of people dying with dignity in their usual place of residence in accordance with their wishes, with a 5 % increase from 2010 to 2015. These local figures are broadly in line with the national average and are higher than most of our comparator areas.
- National minimum data for the whole specialist palliative care service is collated and presented to the steering group. This provides the current national comparator data for analysis.
- Barnsley Hospital is involved in the National Care Of The Dying Audit for acute care and results against national indicators are positive. Action plans for areas of development, identified in the Strategy have been developed which take into account an individual's spiritual needs and advance care planning.
- A range of patient and family feedback, from all areas, is also collated which has shown positive outcomes.
- To develop a future quality monitoring standard, the steering group has agreed that the use of patient outcome measures should be developed, supporting outcome monitoring relating to personalised need. The specialist palliative care teams are beginning to use the validated measures and this will support future outcome measurement and act as the basis of further palliative care development. Nationally, it is anticipated that it may be sometime before bench mark comparisons with other services can be made but this is a positive start. The specialist palliative care team as a whole is working on this development and will provide regular progress reports to the steering group.
- Further data regarding those not involved with specialist services is also required. Here, the steering group has acknowledged that to gain meaningful data to support evaluation and development, a more effective

palliative care template in primary care is needed. It has been agreed by the steering group that the development of GP templates will be prioritised in 2017

- Barnsley Hospital, SWYPFT community services and Barnsley Hospice have all had CQC inspections in the past 2 years and all areas received overall good judgements for end of life care with Barnsley Hospital receiving an 'Outstanding' judgement for the end of life care caring element of inspection and the SWYPFT receiving a similar judgement for end of life care effectiveness. It was acknowledged in the report for community services that greater access for those with a non cancer diagnosis to specialist palliative care should be developed and work is been taken to develop this.
- Baseline monitoring against NICE quality assurance guidelines is provided to the end of life care steering group as well as through a range of audits and annual reports.

6.4 Recommendation 3: Robust education and training for clinicians to embed service development

- A district wide education and training programme has been developed which is inclusive of all health and social care providers across Barnsley. This approach supports integration and partnership working. In 2015 – 2016 a total of approximately 1000 staff accessed formal end of life care training. In addition, there was a significant amount of practice based training/coaching to support implementation of good practice. Recently, the programme has included the roll out of a 1 day advance communications skills training session for senior staff which is an accredited course and has been attended by 72 staff including 21 consultants. A further 6 sessions are planned for 2017.
- The education programme supports the use of various end of life care tools, including the Amber Care Bundle which is a nationally recommended tool for use in acute care. It was developed by Guys and St Thomas' Hospital to support improved treatment planning for those reaching the end of life. Integral to this is the need to have open and honest conversations with the person and their family to support personalised planning and respect of personal preferences and wishes. This has now been introduced in all the medical wards in Barnsley Hospital and additional fixed term facilitator funding from the CCG is supporting further embedding of this approach.
- Locally, following the independent review of the Liverpool Care Pathway a care plan template has been developed to support a personalised approach to end of life care. This has been introduced in all care settings,

locally. Families are encouraged to be involved particularly in considering the holistic needs of the person and their own needs. The “My Care Plan” approach has, recently, been reviewed and updated in response to the latest NICE guidance. The use of the care plan and education about the provision of last days of life care is supported by the Palliative and End of Life Care Teams, who have a visible presence in clinical areas.

- Personalised care planning has been the focus for end of life care development for a number of years and this has included education in all areas regarding advance care planning. In the last year there has again been support particularly in the community and care home sector.

6.5 Recommendation 4: Review and implementation of an Electronic Palliative Care Coordination System

- ‘Planning My Future Care’ templates have been developed for community teams to support the documentation and sharing of practice in advance care planning and to support care/treatment in a way which reflects the individual’s preferences. Our objective is to develop broader ownership of this information to include the hospice, primary care, acute care, social care services and out of hours services, through interoperable ICT systems.It is a national recommendation for local areas to introduce an EPaCCS system by 2018.

6.6 Recommendation 5: Embedding improvements into local service delivery

- In the past year, 7 day provision has been extended to include Hospital and Hospice Specialist Palliative Care Teams and significant benefits are being seen from this development
- A gap analysis has been completed against a number of recent documents which has included an end of life care commissioner check list (2016), NICE guidelines for care of dying adults in the last days of life (2015), Government response to the Independent review of end of life care (2016) and NHS England Specialist Level Palliative Care: Information for Commissioners (2016). This will result in the development of outcome measures, further development of district wide guidelines and district wide audit, shared referral criteria and increased collaborative working.
- To enhance service responsiveness and support for both patients and other professionals, the community team has developed an advice line which is operated by a duty nurse from 9am to 5pm Monday to Friday. Further, the Hospice has established a dedicated triage nurse to discuss admissions to the inpatient unit, together with incorporated telephone advice availability into doctors rotas.

- Within the neighbourhood teams and community services, there is a requirement to identify a key worker for all patients to provide additional capacity in the coordination of care for those with palliative and end of life care needs. Recent experience, in Airedale has shown that positive outcomes can be achieved with the introduction of a one number advice line for palliative/end of life care patients and this practice is under consideration, locally.
- The local palliative and end of life service specification will be reviewed for effectiveness, in 2018/9 as palliative care currencies and outcome measures are developed nationally.

7.0 Further Developments In Palliative Or End of Life Care In The Borough

7.1 The end of life care steering group is currently considering the key priorities for development of the service in 2017/18 and these are to be presented to the CCG in the next few months. These are likely to include the following:

7.1.1 Personalised Care Planning

- Further development of Electronic palliative care coordination system across all providers
- Further development of patient outcome measures for specialist palliative care services
- Need for continued education embedding of AMBER care bundle and advance care planning

7.1.2 Access To Services

- To consider access to a single point of advice for individuals approaching the end of their lives and their families
- The development of multidisciplinary out patient clinics including palliative medicine, nurse and other practitioner involvement to improve geographical accessibility
- To continue to improve access for those with a non cancer diagnosis, through integration into long term condition service specifications, further development of the Map of Medicine and further work to support the recognition of palliative/end of life care need .
- Development of access to psychological and spiritual care

7.1.3 Extending Choice

- To evaluate the need for specific beds (for example in care homes) identified for palliative care and led by palliative care services to allow increased choice regarding place of death.
- To further support the development and models of working in care homes to develop clinical leadership for care home residents who are approaching the end of life
- To link end of life care developments to current work being completed by the *'Living With And Beyond Cancer'* work stream
- To further consider links to personalised budgets for palliative and end of life care

8.0 Independent Review Of Choice In End Of Life Care: Government's Response

8.1 The Government's response to the Independent Review highlighted the need to prioritise end of life care, work collaboratively and provide integrated services. It also made a commitment regarding expectations at the end of life which are summarised below:

- Honest discussions between care professionals and dying people
- Dying people making informed choices about their care
- Personalised care plans for all
- The discussion of personalised care plans with care professionals
- The involvement of family and carers in dying peoples care
- A key contact so dying people know who to contact at any time of day

9.0 Conclusion And Next Steps

9.1 This report sets out the developments which have resulted in the current level and range of provision for palliative or end of life care in the Borough, based upon the local Strategy.

9.2 This is characterised by a consistent focus on individual needs, wishes and preferences and personalised care planning. The involvement of families and carers has been a key consideration with services having been positively reviewed by the CCG and externally assessed by the CQC and bench marked against national data. In line with the Government's response to the outcomes of the recent independent review, there has been a continued focus on the

priority development of collaborative and integrated services which is guided by the district wide end of life care clinical steering group.

9.3 In acknowledging these strengths, there is also a willingness to develop services, further, particularly for those with a non cancer diagnosis and in access to services. The Service is committed to further improvements in personalised care planning and extending choice, again, in line with the Government's response to the independent review..

10.0 Resource Implications

10.1 There are no resource implications arising from considering this report.

11.0 Appendices And Background Papers

11.1 There are no appendices to this report. Background papers used in the compilation of this report are available to view by contacting Karen Sadler, People Directorate, Barnsley MBC, PO Box 639, Barnsley S70 9GG, telephone (01226) 773836 or e-mail karensadler@barnsley.gov.uk

Commissioning Intentions 2017/18 – 2018/19

This paper sets out the NHS Barnsley Clinical Commissioning Group commissioning intentions for 2017/18 to 2018/19.

In the interests of openness, transparency and partnership working, all NHS Barnsley CCG commissioning intentions are set out below for all providers, interested parties and the public to see.

Setting the Context

In 2017/18 and 2018/19 NHS Barnsley CCG are committed to working together to make significant steps forward in transforming health and care services in Barnsley and particularly making progress against the commitments set out in the NHS Five Year Forward View and towards our long term ambitions to move care closer to home. We will do this through delivering the Sustainability and Transformation Plan (STP) for the whole of South Yorkshire and Bassetlaw (SYB) and our local commissioning intentions are a subset of the collective commissioning intentions for SYB.

In line with STP plans, in 2017/18 and 2018/19, there will be no non recurrent support provided for the delivery of 7 day services other than that which is funded through the national tariff.

Providers are asked to consider the collective SYB commissioning intentions alongside these local intentions. Our local intentions reflect our ambition over the next two years to:

- Have a greater focus on prevention and reduction in health inequalities
- Transform the models for service delivery across health and care in Barnsley;
- Focus on self-care, by promoting universal information and advice and sign posting people earlier to a range of community based support
- Combine earlier intervention with greater use of short term / targeted interventions

Our values underpin everything we do as commissioners and this paper sets out how we intend to strengthen and improve services for our local population during 2017/18 and 2018/19. Our values are:

- Equity and fairness
- Services are designed to put people first
- They are needs led and resources are targeted according to needs
- Quality care delivered by vibrant primary and community care or in a safe and sustainable local hospital
- Excellent communication with patients

National and Local Process

The national timetable will be adhered to during contract negotiations and contracts will be agreed and signed by the deadline of 23 December 2016. A detailed timetable will be developed and agreed with providers to ensure that a contract position is agreed to achieve contract signature by the national deadline.

Commissioning Intentions

Finance and Activity

Baseline activity will be based on a 3 year average and review of 5 months of activity and forecast projections for 2016/17. Other adjustments will include but are not limited to, the impact of new models of care, new service specifications in development and delivery of the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.

National tariff inflation and efficiencies will be applied to the core contract as per NHS England guidance on publication.

The contracts will remain as pre-existing block or PbR contracts, unless otherwise stated, with activity monitoring in place to support the contract review and performance process; however this is subject to review for services noted within commissioning stances.

Contract Documentation

Contracts will be issued using the National NHS Standard contract unless otherwise stated. All documentation will be reviewed and updated where appropriate.

The Core contract will be awarded for a period of two years, but will be subject to variation for any developments over the contract period as outlined within this document.

CQUIN proposals will be in line with national CQUIN guidance. Work with providers will commence to ensure agreement and delivery of CQUIN schemes.

Commissioning Stances

Accountable Care Organisation Barnsley CCG has an ambitious strategy to integrate the delivery of health and care for the people of Barnsley. This ambition is supported by our commissioning partners in Barnsley Metropolitan Borough Council and our provider partners in BHNFT and SWYPFT and by the Barnsley Healthcare Federation. The partners have come together with the CCG to form an Accountable Care Partnership Board. Our vision for the future of health and care in Barnsley is to create a simpler, more joined up health and care system; one where the people of Barnsley don't see organisational boundaries. Instead, they experience continuity of care; they see familiar faces that are clearly connected to each other regardless of

where patients are seen; be that in hospital, in the community or at home. Our goal is to dismantle boundaries at the point of delivery of care, to create a Barnsley where patient interests come first and resources are focused on improving health outcomes in areas of Barnsley where inequalities are greatest.

Although our end goal is a truly integrated Accountable Care Organisation which moves the boundaries between commissioning and provision, our first step on the journey is to see an integrated provider model up and running from 2017/18, working as a virtual **Multispecialty Community Provider** and covering the following services, where work on the new model of integrated care is already most advanced:

- Intermediate care
- Diabetes care
- Respiratory care
- Community Nursing

Our expectation is that we will enter into alliance contractual arrangements with current providers of the services. We will look to sign off care models and agree the timetable for implementation of integrated pathways and performance outcomes with providers collectively, as part of the forthcoming contracting round. As well as a shared vision for the care model, the alliance agreement is expected to cover providers commitment to managing resources together, to realising the opportunities offered for Barnsley's population in Rightcare: Commissioning for Value, as well as clear governance and gain/risk sharing arrangements to secure best value from existing resources. We would expect to have moved to the new alliance contract by September 2017.

NHS Barnsley CCG is committed to working as part of the **Commissioners Working Together Programme** to deliver regional based commissioning where there is a cohesive evidenced based case for change which identifies a need to commission services on a wider geographical footprint. Increasingly this will become part of our approach to strategic commissioning through SYB's STP. In 2017/18 progress is expected to be made with regards Hyper Acute Stroke Services (HASU) commissioning and Children's Surgical and Anaesthesia Services.

Commissioning For Value - In line with NHSE expectations the CCG will explore 100% of the opportunities identified within the RightCare Commissioning for Value packs, the CCG will take a structured approach to the analysis of the opportunities for improvements in care, outcomes and cost efficacies highlighted in the Right Care Commissioning for Value (CvF) packs, examining both the overview packs and the focus packs. This will be a key part of how the South Yorkshire and Bassetlaw Sustainability and Transformation Plan will be taken forward in Barnsley.

This will lead to the development of action plans and, where necessary service redesign, to realise improved health outcomes, decrease in unwarranted variations in care and improve cost efficiency. The analysis may result in the need to amend care pathways and current service specifications, or to re-procure services, within the contract period.

Providers will be expected to work proactively with the CCG in helping to clarify the opportunities, develop and implement the action plans and respond to the changing opportunities across the contract period.

For Barnsley CCG the data provided in the 'Where to Look Packs', published in January 2016, suggests a total saving opportunity of £23m if Barnsley performed at the efficiency of its top 10 peers.

The £23m can be broken down as follows:

Area of Opportunity	Value of Opportunity £m
Cancer and tumours	1.6
CVD (circulation problems)	3.9
Endocrine, metabolic and Nutrition problems	1.6
Gastrointestinal	3.4
Genitourinary	0.6
Mental Health Prescribing	0.9
MSK	3.7
Neurological	3.3
Respiratory	3.5
Trauma and injuries	0.5
Total Opportunities	**23**

Commissioning for Value packs currently at implementation stage include:

- Medicines management (medicines form part of all areas outlined above)
- Musculoskeletal (MSK) disease and trauma
- Respiratory Disease
- Complex patients (part of the 2016 overview pack)

The next area to be examined in depth and implementation commenced is cardiovascular disease. A staged approach to review, service redesign and implementation of all the others will begin in 2017/18 and providers are asked to be aware of the impact this will have on services and contracts over the two year planning period and to work with the CCG to secure the outcome and efficiency opportunities available. An overview of the opportunities currently being taken forward is attached at Appendix A.

The CCG will look to introduce a fast track process to take forward commissioning for value. Other commissioning for value opportunities not listed above but emerging during the 2017-19 contract period will also be subject to the fast track process.

Further detail for providers on Commissioning for Value and the opportunity for Barnsley can be found at http://www.rightcare.nhs.uk/index.php/commissioning-for-value/

To maximise the opportunity afforded to us by commissioning for value, the CCG will re-specify and re-procure **MSK services** in 2017/18.

To maximise the opportunity afforded to us by commissioning for value the CCG will review **pain management services** which may lead to re-procurement during the period of the 2017-19 contract.

Demand Management Tools - The CCG is committed to ensuring that patients who need access to specialist advice and treatment can receive high quality advice in a timely manner. Demand for elective care continues to rise and the CCG is considering how to manage that demand whilst ensuring patients receive access to treatment in line with their constitutional right. To meet national guidance on demand management the CCG has commissioned the **Map of Medicine** Referrals product and will begin roll out in October 2016 to all practices in Barnsley, with the aim of:

- Improving the quality of care to patients prior to referral, by providing standardised agreed local pathways, including prescribing information, best practice models and linkage to the most appropriate investigations and onward referral as necessary.
- Reducing the volume of inappropriate referrals to secondary care in targeted specialties/pathways where we have commissioning for value opportunity.
- Improving the appropriateness and speed of referrals and ensure patients are treated in the most appropriate environment.
- Supporting GPs by providing agreed pathways in a single location (i.e. on their clinical system).

The CCG intends to cover the following elements of the **national guidance on demand management** in our approach:

- Alternatives to outpatient appointments – transforming the way outpatient clinics are delivered, offering alternatives to traditional face to face clinics. We would expect this to be a component of the MCP model for diabetes and respiratory services
- Shared decision making - a process in which patients, when they reach a decision crossroad in their health care, can review all the treatment options available to them and participate actively with their HCP in making decisions.
- Choice – giving patients control to shape and manage their care and make meaningful choices
- Advice and guidance - To help to avoid the need for outpatient referrals, during 2017/18 the CCG will develop with BHNFT a process for the provision of consultant 'Advice and Guidance' to primary care via e-mail and / or by phone. Along with this, we will work with BHNFT to increase the provision of clinical interpretation and management advice given on the reports of clinical investigations. During 2017/18 both the provision of consultant advice and guidance and increased clinical advice on investigations will be piloted for cardiology.

Primary Care – Primary care services are the front door of the NHS but general practice is under pressure after years of relative under investment. The **General Practice Five Year Forward View** sets out a national programme to invest £2.4bn in primary care by 2020/21. Investment of approximately £23m will come from national transformation funding sources, on a SYB STP footprint, across a 5 year period and in line with national planning guidance the CCG is expected to make available from its baseline allocation indicative sums of £1.3M over the 2 year operational planning period. Investment is aimed at:

- Supporting and growing the workforce
- Improving access to general practice in and out of hours
- Transforming the way technology is deployed and infrastructure utilised
- Supporting practices to better manage workload and redesign how care is provided

NHS Barnsley CCG will be looking to support significant development of primary care services during 2017/18 and 2018/19 to ensure the local delivery of the General Practice Forward View. The CCG will be focusing on the following key priorities:

- **Clinical Practice Pharmacy development**. This is designed to integrate the role of Clinical Pharmacists into General Practice. The aim is to increase capacity of GPs and Practice Nurses, through the principle of patients being treated by the right clinician at the right time. Furthermore addition of Community Pharmacists within Practices will increase quality and safe prescribing; maximise cost effective prescribing and reduce prescribing queries.
- **Development of Primary Care training programmes.** Barnsley CCG recognises the shortage of GPs and Practice nurses. We have developed an apprenticeship training scheme encouraging administrative staff to become Health Care Assistants and for Health Care Assistants to receive further clinical skills training, to complement the existing workforce in practice. A scoping exercise will be undertaken to identify the potential for the development of a Practice Nurse and Advanced Nurse Practitioner training programme to address other workforce elements of the Primary Care Strategy.
- **First Port of Call Training** – We will look to roll out this training across all practices and develop receptionist / care navigation roles to harness the significant untapped potential within this element of the workforce.
- **GP Fellowship Scheme** – we will implement with partners, a GP Fellowship Scheme providing added value to newly qualified and new to Barnsley GPs, in a programme which will provide added value to their professional expertise and will support recruitment and retention, working in new models of care delivery.
- **Further Development of the Vocational Training Scheme** – GP recruitment and retention is a significant issue in Barnsley with only 54 GPs per 100,000 population against the national average of 65+. The number of Training Practices in Barnsley has increased only marginally over the last ten years, and expansion would improve recruitment and retention. The CCG therefore

has an ambitious aspiration to achieve training practice standards at all practices in Barnsley whilst accepting that not all practices will be trainers. Locality working and buddying systems will be explored as ways of managing training rotations across the borough.

- **Productive Primary Care** – our intention is for all practices to be engaged with the national development programme to accelerate the 10 high impact changes to release time for care
- **Primary Care at Scale** Barnsley CCG already has an at scale Federation in place, Barnsley Health Care Federation (BHF). In line with the aspiration set out in the GPFYFV the CCG will continue to support BHF to play a central part in developing new models of care, through the development of the Multispecialty Provider model outlined earlier which will integrate the provision of primary and community services. BHF are also exploring a back office function offer to practices to support them to better manage workload, harness advances in technology and capture economies of scale.
- The CCG will work with both BHF and the Local Medical Committee (LMC) to introduce a local scheme to support struggling practices. The CCG and partners are coproducing "**The Practice Doctor**" - this initiative will provide a combination of local expertise and private providers to wrap a support package around practices who are finding it difficult. In signing up to the scheme practices will be supported to develop their own plan to deliver sustainability and key outcomes for registered patients. A business case will be submitted to access the funding available through the General Practice Resilience Programme.
- **The Practice Delivery Agreement (PDA).** The PDA is designed to support the delivery of quality Primary Care Services. This work began in 2015 and will continue throughout 2017 and beyond. The PDA will be co-produced with Barnsley GP Practices and will be directly informed by patient need and known health inequalities. The role of the PDA will strengthen Primary Care services by facilitating working at scale and as a direct result deliver improved patient outcomes.
- **Developing locality models** – The CCG will be working with member practices to develop a locality alignment model. Developing the concept of "Neighbourhoods" – this model will facilitate resources to be wrapped around groups of practices and create a focus for outreaching services and delivering primary care at scale in "Neighbour Hubs", matched to the local Area Council areas. The initial development of this new model will be focussed on the Community Nursing Review, and revised resourcing, the alignment of 0-19 services and on improving the offer for patients in care homes.

In addition, in primary care:

- The **Year of Care Model** supports practices to facilitate the transformation of Long Term Condition annual reviews and to support patient centred-consultations to facilitate change in health related behaviours. A focus on the approach will continue in 2017/18 and 2018/19.
- **Reviewing and commissioning more integrated Out of Hours Urgent and Emergency Care Pathways in line with the national commissioning standards for integrated urgent care. This will include:**

    - Extended access to core Primary Medical Services - The Prime Ministers Challenge Fund (i-Heart Barnsley) service has been extended by NHSE until April 2017. From October 2016 extended GP core services will be required to be provided at a level of 30 minutes per 1,000 population funded at £6 per head of population this will require access to core services on evenings and weekends with clear criteria and KPI's to ensure national consistency.
    - Out of Hours Primary Medical Services

  The CCG will be working with all providers of out of hours services to explore how an integrated out of hours and urgent and emergency care service that aligns to national requirements can be delivered from 2017/18.
- **Cancer shared care** - Following a review of the way in which prostate and colorectal cancer follow-up appointments are delivered in Barnsley, in 2017/18 the focus will be on moving the care of stable patients for all tumour sites to primary care. This will ensure that secondary care appointments remain available for patients with greatest need and where possible patients requiring only a check-up receive the appropriate level of care closer to home. These changes will need to be reflected in both the primary and secondary care contracts.

Integrated Personalised Commissioning (IPC)/ Personal Health Budgets (PHB)- Building on the progress made by the Health and Social Care Community during 2016/17 and in the context of integrated pathways and the development of Accountable Care, IPC will be developed at pace and scale to meet the needs of the top 5% of people in Barnsley with the most complex needs in the following cohorts:

- Children and Young People
- People with Continuing Care Needs
- People with complex and enduring Mental health problems
- People with Learning Disabilities
- People with Long Term Conditions

Barnsley CCG has commissioned a new **Social Prescribing** service to facilitate access for patients to non-medical form of support within the community. During 2017/18, Barnsley CCG will work with the service provider to mobilise the service and with health care providers, the voluntary sector and other partners, patients/carers and local communities to develop referral pathways into and from the service.

Learning Disabilities Transforming Care - In line with the Barnsley, Kirklees, Calderdale and Wakefield Transforming Care Partnership and Programme, Barnsley commissioners will work with the Partnership and with the provider to: develop and re-specify the specialist LD community model in line with the national service model; develop and specify specialist LD crisis response function; monitor usage and length of stay of commissioned assessment and treatment beds; Develop an all age 'at risk of admission' register for people with LD and/or autistic spectrum disorder. Revised service specifications will be included in contract negotiations for 2017/18 and will be aligned financially to the overall contract.

The **Adult Autism and ADHD Service** has received additional non-recurrent funding in 2016 to clear the backlog of people waiting for assessment. During 2017/18 the waiting list will be cleared and a sustainable service model based on known demand will be delivered through provision of additional funding from the commissioner as per the 2016/17 agreed levels as well as improved shared care arrangements with primary care, secondary care mental health services and adult social care.

Shared Lives - The CCG will continue to work jointly with BMBC Communities Directorate to expand the offer of the current Shared Lives Scheme to support people with physical health needs from 1 June 2017. A range of support in the Shared Lives carers' home (day care, respite, recuperation, up to 6 week stays for rehabilitation and long term placements) will be available to people who:

- Have had frequent admissions to hospital
- Are frequent attenders to primary care
- Need a period of general, stroke or neuro rehabilitation but are unable to return directly home
- Need a period of recuperation following hospital admission
- Have Continuing Health Care Needs or have multiple/complex health needs giving eligibility for a personal health budget
  Require end of life support, including respite for families in their caring role

There will be a need for primary care and community services (especially therapy teams) to provide in reach support to patients residing in Shared Lives carers' home as per the support that would have been offered if they were residing in their own home.

Based upon experience during year one as to the types of patients and type of support that there is the most demand for, from 2018/19, the activity level of certain contracts (e.g. residential care based intermediate care) may need to be adjusted.

Mental Health - Having considered the implications for Mental Health Services of the 'NHS Operational Planning Guidance 2016/17 – 2018/19' a range of commissioning stances have been developed which span the breadth of mental health services. These include:

- Support continued implementation of the All-age Mental Health and Wellbeing Commissioning Strategy. This will include exploring opportunities to develop locality models in line with those described in the Primary Care section above.
- Expansion of IAPT to increase access in line with national recommendations – to incorporate Long Term Conditions.
- Support continuation of Recovery College model (no additional resources required) as there are robust links with IAPT. Commissioners will use the findings from the provider review of the Barnsley Recovery College model and costs and published evidence base to determine whether the model could deliver improved outcomes and greater accessibility in a more cost effective way to support Mental Health 5 Year Forward View priorities. This commissioner review in 2017/18 may lead to changes in 2018/19.

- Continue to support Early Intervention and Prevention (EIP) services to achieve national access and waiting time standards.
- Support the CORE 24 24/7 Psychiatric Liaison service and either:
    - Support expansion of the current service to enable access to 16+ year olds, or
    - Develop CAMHS service to provide psychiatric liaison services to 16 and 17 year olds
- Support the development of a Specialist Perinatal Mental Health Team and the continuation of the Specialist Mental Health Midwife role at BHNFT (via Specialist Development Fund application) in the first instance.
- Continue to implement the Barnsley Local Transformation Plan to improve the emotional health and wellbeing of children and young people in Barnsley.
- Support the development of a crisis café, linked to the Department of Health Place of Safety allocation process in parallel with supporting the accessing of funding to re-establish a street triage service – both elements are fully endorsed by the Barnsley Mental Health Crisis Care Concordat.
- CYP IAPT – support the ongoing delivery and developments to ensure continuation of robust service delivery, in light of reduced financial support from NHS England.
- Support the continuation of the Yorkshire and Humber Veterans Mental Health Outreach Service located in Hull.
- Work with service providers to reduce the lengthy waits for Psychological services.
- Primary care mental health – support the introduction of an increased number of mental health therapists, as nationally recommended.
- Support the Barnsley Suicide Prevention Strategy and implementation of the Suicide Prevention Action Plan, currently out to consultation

The CCG, with partners, will further develop **services for people with dementia** ensuring high quality throughout the pathway, including for patients in care homes, that reflects the priorities within the Prime Ministers Challenge on Dementia 2020

Building on the successful development of **RightCare Barnsley** further work will be undertaken to deliver the re-specified **'Intermediate Care'** (IC) offer which will include RightCare Barnsley as the broker to all out of hospital services in the borough. This will include the re-specified **Community Nursing** offer implemented in Quarter 3 of 2016/17, improved support to patients in Care Homes and consideration of how the Care Navigation Service and Falls Service resources can be utilised in a more integrated way within the IC offer. This integrated service offer will be managed by an alliance contract, assisted by locality working, and will be a key vehicle to modelling the work required in MCP development and the focus and operation of the Accountable Care Organisation described earlier. In addition, through the use of the Medworxx Tool and its role as gatekeeper to hospital care, RightCare Barnsley will maximise the best use of both hospital and out of hospital resources for the benefit of the Borough's health and social care system.

Diabetes and Respiratory Services - New service specifications for integrated care for diabetes and COPD were agreed with Providers in early 2016. Providers who

are part of the virtual MCP model (BHFNT, SWYFT and BHF) are asked to agree with the CCG their delivery model, activity levels, key performance indicators, milestones for implementation and monitoring arrangements. In addition any clarifications/amendments required to the service specifications will be agreed with Providers by the end of February 2017.

There is a close overlap between the Respiratory MCP service specification and the Respiratory Commissioning for Values priorities. Where appropriate the respiratory CvF priorities will be integrated into the respiratory MCP work. (see Appendix 1)

The agreed respiratory (COPD) service specification also notes the need for the range of conditions included in the MCP model to be expanded to cover other respiratory conditions. This will be developed with Providers during 2017/18 and 2019/18.

Diabetes is also included in the Cardiovascular Commissioning for Value pack. It is possible that once detailed analysis of the pack has been undertaken, that some additional priorities for diabetes will be identified and need to be integrated into the diabetes MCP work.

During 2017/18 we particularly wish to see, for all patients across all our practices:

- A phased move of patients with diabetes currently under secondary care outpatient follow-up who do not have complex needs back to primary care for their ongoing management.
- Commencement of a structured patient education programme for type one diabetes and more patients with type two diabetes being able to access a structured education programme
- Development and implementation of a general, and targeted, offer from respiratory and diabetic specialists to support general practices to develop their skills and confidence in managing patients with these conditions. It is anticipated that this will take the form of training, targeted support to practices, increased availability of advice and joint clinics/telehealth consultations.
- A step change in the numbers of people with COPD being referred for and receiving pulmonary rehabilitation, increasing to 400 by 2018/19.
- A clear pathway for long term oxygen assessment and follow up, and use of oxygen concordance data to inform the review and prescribing of long term oxygen.
- Increase in the proportion of patients with COPD and asthma who have had a primary care annual review within the last 12 months.
- An increase in confidence of primary care staff in the use and interpretation of spirometry; an increase in the proportion of patients whose diagnosis of COPD has been confirmed by spirometry and COPD register validation.
- Primary care proactive case management of patients with frequent hospital admissions from COPD, with support from specialist services where appropriate.

- Increase in the access to respiratory expertise within A&E and closer working between respiratory teams, A&E and RightCare Barnsley to help to avoid admissions.
- Improved discharge support for patients who have been admitted with respiratory disease.

Barnsley CCG is the lead for the STP footprint for the SY&B area for the **National Diabetes Prevention Programme NDPP**. In 2017/18 the CCG will co-produce, with primary care and diabetes specialists, pathways to enhance the early identification and management of people with non-diabetic hyperglycaemia.

Cardiovascular Disease - Building on the work undertaken in 2016/17 with the Cardiology Steering Group and following initial review of the Cardiovascular Commissioning for Value Pack, during 2017/18 and 2018/19 the CCG will:

- Support primary care practices to decrease the variation and 'raise the bar for all' in the quality of primary and secondary prevention for cardiovascular disease and diabetes in primary care
- Work with providers to implement a new referral pathway for patients with suspected heart failure
- Revise the service specification for the Community Heart Failure Service, reflecting new heart failure pathways.
- Review the provision of cardiac rehabilitation and of urgent advice for patients with chest pain, and look at ways to increase direct access to cardiac investigations and advice and guidance to enable more patients to be managed without the need for a cardiology outpatient appointment.

The CCG will work with other commissioners and providers of **Cancer Services** to deliver the National Cancer Strategy and recommendations from the Cancer Task Force. There will be a specific focus on:

- Early Diagnosis – Reviewing diagnostic capacity, increasing the focus on screening programmes.
- Improved Care Pathways to reduce waiting times across the whole pathway from Primary Care through to end of treatment. This will include supporting direct referrals form Primary Care.
- Living with and beyond cancer – Support the delivery of the living with and beyond cancer programme.

Medicines (including use of Summary Care Record/MIG information) Medicines Reconciliation. Transfer of care and discharge management are key issues identified nationally. This Medicines Optimisation commissioning intention is for the introduction of a system for medicines reconciliation to improve communication between care settings and to promote learning and analysis. For 2017/18 this includes:

- Development of medicines related communication systems when patients move from one setting to another to ensure clear information on medication is available to support patient care.

- Discharge transfer of care communication will contain a minimum dataset of information.
- Trusts to code medicines related admissions for analysis, learning and prevention.
- The GP practice information (Summary Care Record or MIG) will be used as the primary source (of the two minimum sources) of information for clinicians undertaking Medicines Reconciliation.

Medicines (High cost drugs/ Homecare) - A high cost drug and homecare service specification has been developed for contract inclusion in 2016/17. This specification defined the requirements of appropriate management of HCD and Homecare medicines. This includes:

- Homecare to be provided in line with Department of Health commissioned paper “Hackett Report”
- Provision of data in line with a minimum dataset (through the nationally commissioned Blueteq system)

Medicines Management commissioning intentions for 2017/18 to expand on the work undertaken in 2016/17 to ensure consistency in approach with NHS England Specialised Commissioning. This includes:

- Homecare delivered in line with the Hackett report (National guidance compliant):
    - Review of existing services to ensure continued benefit and effectiveness.
    - Exploring new and alternative options for homecare service provision (e.g. outsourced outpatient pharmacy)
    - Considering a scope of a procurement solution for Homecare services (as an alternative to existing SBS options).
- High cost drugs delivered in line with the service specification:
    - Development of cost improvement opportunities e.g. biosimilars, batch manufacturing, dose banding.
    - Horizon scanning to allow financial forecasting/planning
    - HCD bench marking to ensure consistency in use across regional trusts (monitored against national and local guidance/pathways)
    - Management of the transfer of commissioning responsibility from NHSE Specialised Commissioning to CCGs
- Service redesign to review existing services to ensure continued benefits for the health economy, this includes: Rheumatology, Gastroenterology and Ophthalmology services. e.g. commissioning of community based ophthalmology services, commissioning AMD services to allow the provision of Avastin through choice.

APPENDIX A

Phase 1Commissioning for Value Priorities

Medicines management	• Comprehensive medicines optimisation programme • Focus on reducing medication wastage • Introduction of clinical pharmacists in primary care
Musculoskeletal disease and trauma	• Review of MSK service • Review of use of injections for low back pain and acupuncture • Implementation of Map of Medicine pathways with hip and knee pain • Review of services for falls and osteoporosis prevention and management
Respiratory Disease	• Increasing uptake of flu / pneumococcal vaccinations • Increasing Stop Smoking service links with clinical pathways • Primary care proactive case management of patients with frequent hospital admissions from COPD – adding COPD patients who have had 3 or more admissions to ProCare Barnsley cohort. • Increase access to respiratory expertise within A&E and closer working between respiratory teams, A&E and RightCare Barnsley to improve the identification of people who could be supported in community rather than being admitted and ensure they get the appropriate community support. • Improved discharge support for patients who have been admitted with respiratory disease • Having a step change in numbers of patients receiving pulmonary rehabilitation, increasing to around 400 a year • Ensure that a clear pathway and service is in place to assess and manage patients who require Long Term Oxygen Therapy (LTOT) • Use Oxygen Supplier's concordance data and tools to inform LTOT management • An increase in confidence of primary care staff in the use and interpretation of spirometry; an increase in the proportion of patients whose diagnosis of COPD has been confirmed by spirometry and COPD register validation
Complex patients	• Roll out of Pro-care to support case management of complex patients in Primary Care
Cardiovascular disease	• Increased focus on 'Making Every Contact Count' and provision of brief advice, and onward referral to services, to support smoking

(based on initial review)	cessation, increases in physical activity, weight management and sensible use of alcohol • Support primary care practices to decrease the variation and 'raise the bar for all' in the quality of primary and secondary prevention for cardiovascular disease and diabetes in primary care • Development of the current Primary Care Health Inequalities Targeted Service (HITS) CVD related indicators including hypertension and AF case finding and management of patients at high risk of developing CVD • Development of care pathways for patients with non-diabetic hyperglycaemia, linking with the national roll out of the National Diabetes Prevention Programme. • Work with providers to implement new pathways for patients with heart failure • Review the provision of: o cardiac rehabilitation o urgent advice for patients with increasing chest pain o look at ways to increase direct access to cardiac investigations and advice and guidance to enable more patients to be managed in primary care without the need for a cardiology outpatient appointment.

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